

04800

4811

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 35yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland			
				d. STREET ADDRESS 647 Terrest Drive.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Oscar Preston Alston				4. DATE OF DEATH April 18 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb 7 1894	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker				10b. KIND OF BUSINESS OR INDUSTRY Hauling trash		11. BIRTHPLACE (State or foreign country) Petersburgh, Va.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Preston Alston				14. MOTHER'S MAIDEN NAME Isabella Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-10-3484		17. INFORMANT Horace Alston Address 618 W. 161st Apt 24 New York City 32 N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 9 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug , 19 58 , to April , 19 59 , that I last saw the deceased alive on April 18 , 19 59 , and that death occurred at 4:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John D Turco M.D. 302 N. POTOMAC ST 4-20-59 PHYSICIAN'S NAME (Type) JOHN D TURCO HAGERSTOWN, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-22-1959		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. ADDRESS Hagerstown Md				24a. REC'D BY REGISTRAR APR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Place of registration	
13. Signature of medical examiner		14. Signature of coroner		15. Signature of jury		16. Signature of witnesses	
17. Signature of funeral director		18. Signature of undertaker		19. Signature of cemetery		20. Signature of burial place	
21. Signature of health officer		22. Signature of county clerk		23. Signature of state registrar		24. Signature of state auditor	
25. Signature of state treasurer		26. Signature of state comptroller		27. Signature of state attorney		28. Signature of state judge	
29. Signature of state legislator		30. Signature of state senator		31. Signature of state representative		32. Signature of state official	
33. Signature of state employee		34. Signature of state contractor		35. Signature of state vendor		36. Signature of state purchaser	
37. Signature of state agent		38. Signature of state broker		39. Signature of state dealer		40. Signature of state merchant	
41. Signature of state trader		42. Signature of state exporter		43. Signature of state importer		44. Signature of state manufacturer	
45. Signature of state wholesaler		46. Signature of state retailer		47. Signature of state distributor		48. Signature of state transporter	
49. Signature of state carrier		50. Signature of state messenger		51. Signature of state courier		52. Signature of state mailman	
53. Signature of state postman		54. Signature of state telegrapher		55. Signature of state telephone operator		56. Signature of state electrician	
57. Signature of state plumber		58. Signature of state carpenter		59. Signature of state painter		60. Signature of state mason	
61. Signature of state bricklayer		62. Signature of state cooper		63. Signature of state saddler		64. Signature of state shoemaker	
65. Signature of state hatter		66. Signature of state jeweler		67. Signature of state optician		68. Signature of state pharmacist	
69. Signature of state druggist		70. Signature of state veterinarian		71. Signature of state dentist		72. Signature of state physician	
73. Signature of state surgeon		74. Signature of state obstetrician		75. Signature of state gynecologist		76. Signature of state ophthalmologist	
77. Signature of state otolaryngologist		78. Signature of state dermatologist		79. Signature of state allergist		80. Signature of state immunologist	
81. Signature of state epidemiologist		82. Signature of state infectious disease specialist		83. Signature of state public health officer		84. Signature of state health commissioner	
85. Signature of state health secretary		86. Signature of state health assistant		87. Signature of state health inspector		88. Signature of state health examiner	
89. Signature of state health auditor		90. Signature of state health accountant		91. Signature of state health statistician		92. Signature of state health researcher	
93. Signature of state health educator		94. Signature of state health promoter		95. Signature of state health advocate		96. Signature of state health lobbyist	
97. Signature of state health lobbyist		98. Signature of state health lobbyist		99. Signature of state health lobbyist		100. Signature of state health lobbyist	

11-11-11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04799

Reg. Dist. No.

4812

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASH. D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLETOWN</u> 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>STATE HOSP.</u>		d. STREET ADDRESS <u>113 E. MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lelia Frances Andrews</u>		4. DATE OF DEATH Month Day Year <u>April 7, 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1908</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM SMITH</u>	
14. MOTHER'S MAIDEN NAME <u>CARRIE LITTEN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>213-24-8012</u>		17. INFORMANT <u>Mrs. Lela V. Stine</u> Address <u>Middletown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema + peritonitis</u> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>generalized carcinomatosis</u> DUE TO (c) <u>ovarian carcinoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 mos.</u> <u>13 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 25, 1959</u> , to <u>April 7, 1959</u> , that I last saw the deceased alive on <u>April 7, 1959</u> , and that death occurred at <u>6:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Beren</u>		ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE. M.D.</u> DATE SIGNED <u>4/8/59</u>	
PHYSICIAN'S NAME (Type) <u>DR. G. BERCU</u>		<u>HAGERSTOWN, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL</u>	22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraus</u> ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

W. VA. STATE

1911

STATE

FEMALE WHITE

DECEASED

VIRGINIA

GRABIE LITZEN

WILLIAM SMITH

NO

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04801

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 16 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hagerstown R # 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. County Hospital				d. STREET ADDRESS near Funkstown	
3. NAME OF DECEASED (Type or print) OSCAR MASON ARTZ			4. DATE OF DEATH Month April Day 22 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan'y 5 1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Md. Downsville Wash. Co	
13. FATHER'S NAME Samuel Artz			14. MOTHER'S MAIDEN NAME Harriett Stiffler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Howard M. Artz Hagerstown Md. R # 3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.5 DUE TO Fractured Skull(closed) & shock Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] Fell over wagon			
20c. TIME OF INJURY Month, Day, Year 10:30 a.m. Apr. 22 '59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
		20f. (City or town) Rural Funkstown Wash Md		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-23-59	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
				22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.			24a. REC'D BY REGISTRAR APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATISTICAL EXAMINER'S CERTIFICATE OF DEATH
MASTERS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NEW YORK
COUNTY
CITY OF NEW YORK
WILLIAM
JAMES
JANUARY 1910

WILLIAM JAMES
JANUARY 1910

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
WILLIAM JAMES		35		Male		White		Roman Catholic		Single		Laborer		Heart Disease		Home		January 1, 1910		10:00 AM		[Signature]		[Signature]		[Signature]		[Signature]	

CERTIFICATE OF DEATH

04802

Reg. Dist. No.

4814

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 669 Forest Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last BAKER		4. DATE OF DEATH Month April Day 23 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1902
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Myersville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Barnes		14. MOTHER'S MAIDEN NAME Catherine Weddles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-0571	
17. INFORMANT Mrs. R. B. Nicklas		Address 220 N. Potomac St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 days 12 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I attended the deceased from Apr. 4, 1959 , to Apr. 23, 1959 , that I last saw the deceased alive on Apr. 23, 1959 , and that death occurred at 8:30 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Robert Wells		ADDRESS (Street, city or town, state) 115 N. Potomac Street DATE SIGNED 4-24-59	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE APR 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hall	

Wm. C. Host v. Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4815

CERTIFICATE OF DEATH

04803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Violet Middle May Last Baker		4. DATE OF DEATH Month 4 Day 29 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29. 1914
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 6 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Mt. Union Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Swan		14. MOTHER'S MAIDEN NAME Agnes Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Charles M Baker		Address 132 E. Main St. Hancoek Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x hepatic coma DUE TO (b) diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 3/17/59 , 19____, to 4/29/59 , 19____, that I last saw the deceased alive on 4/29/59 , 19____, and that death occurred at 12 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Howard N. Weeks , M.D. 136 North Potomac St. 5/1/59 PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Md.			INTERVAL BETWEEN ONSET AND DEATH several weeks
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5.2.59	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Allegany Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard N. Weeks		24a. REC'D BY REGISTRAR DATE MAY 5 '59	
ADDRESS Hagerstown Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kram	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

NOV 10 1915

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
123 Main St, Baltimore, Md.		Teacher		Heart Disease	
Date of Death		Place of Death		Physician	
Nov 5, 1915		Home		Dr. J. Smith	
Time of Death		Burial Place		Burial Date	
10:30 AM		Catholic Cemetery		Nov 10, 1915	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Name of Coroner		Name of Registrar		Name of Physician	
John Doe		Jane Doe		Dr. J. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4816

CERTIFICATE OF DEATH

Reg. Dist. No. 04804

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Fulton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burnt Cabins 75x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>Kell</u> Last <u>Baldwin</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1895</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>20</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shade Gap, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer E. Kell</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Neil</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>C. Stull Baldwin, Bt. Cabins, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aplastic anemia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Mar. 19</u> , 19 <u>59</u> , to <u>Apr. 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Apr. 3</u> , 19 <u>59</u> , and that death occurred at <u>1:42 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>145 S. Prospect St Hagerstown Md</u> DATE SIGNED <u>4/5/59</u>							
ACTUAL SIGNATURE <u>R. S. Stauffer</u>		M.D. <u>145 S. Prospect St Hagerstown Md</u>					
PHYSICIAN'S NAME (Type) <u>R. S. STAUFFER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 7, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Orbisonia</u>		22d. LOCATION (City, town, or county) (State) <u>Orbisonia Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Linsinger, Mechanicsburg, Pa.</u>				24a. REC'D BY REGISTRAR <u>DATE APR 16 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

4817

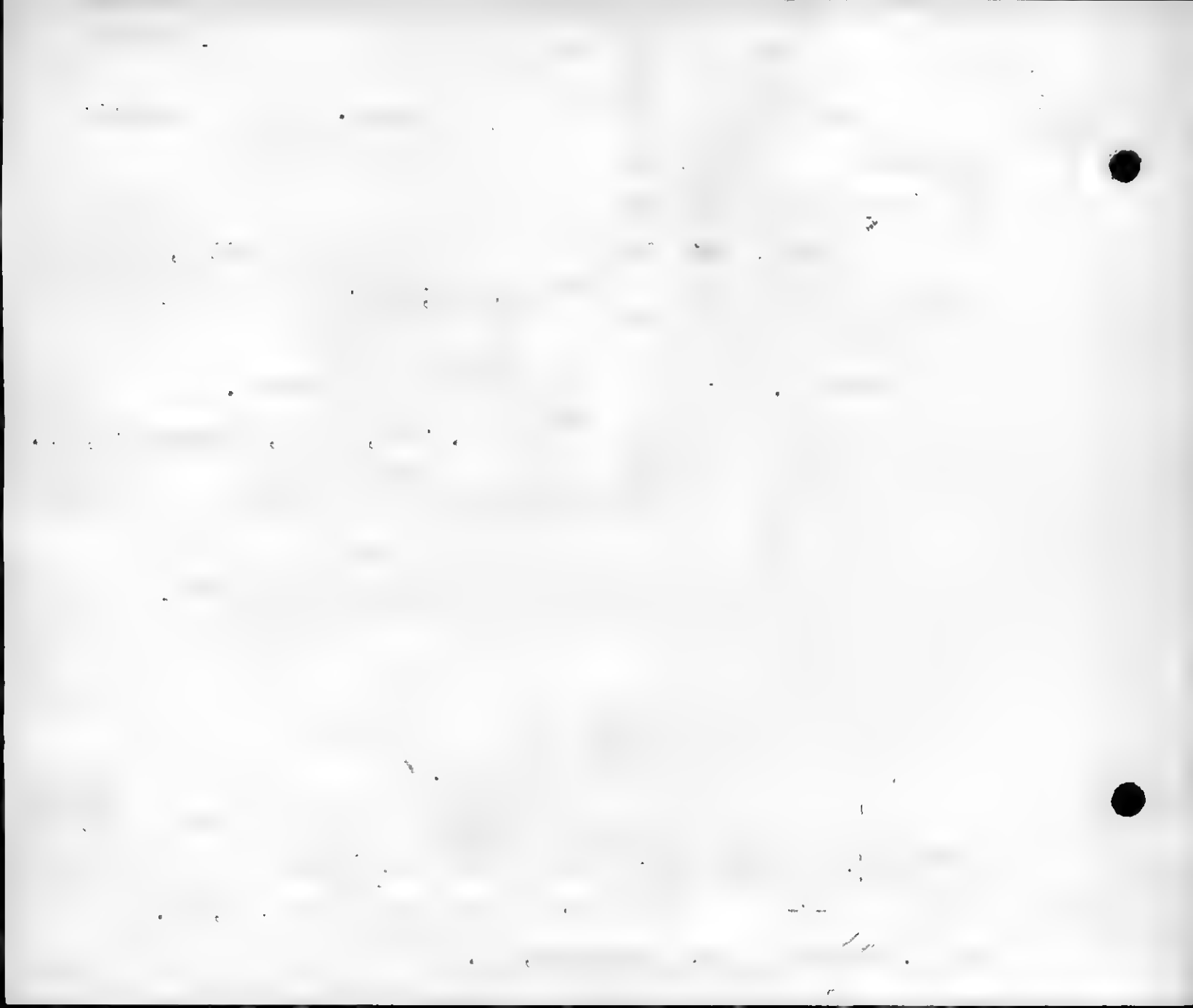
CERTIFICATE OF DEATH

04805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Penna. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle	
f. NAME OF DECEASED (Type or print) First David Middle Scott Last Barr		g. DATE OF DEATH Month April Day 6 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1959
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David H. Barr		14. MOTHER'S MAIDEN NAME Judith A. Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -	
17. INFORMANT David H. Barr, RFD 3, Greencastle, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis DUE TO (b) Prematurity (Amas) DUE TO (c) Prematurity (Amas) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 24 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/5/59 , 19 4/6/59 , that I last saw the deceased alive on 4/6/59 , 19 4/6/59 , and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE SEARL Young		DATE SIGNED 4/7/59	
PHYSICIAN'S NAME (Type) SEARL YOUNG MD Hagerstown		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-8-59	
22c. NAME OF CEMETERY OR CREMATORY Salem Church Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House			

2081201XVI



FOR STATE
HEALTH DEPT.

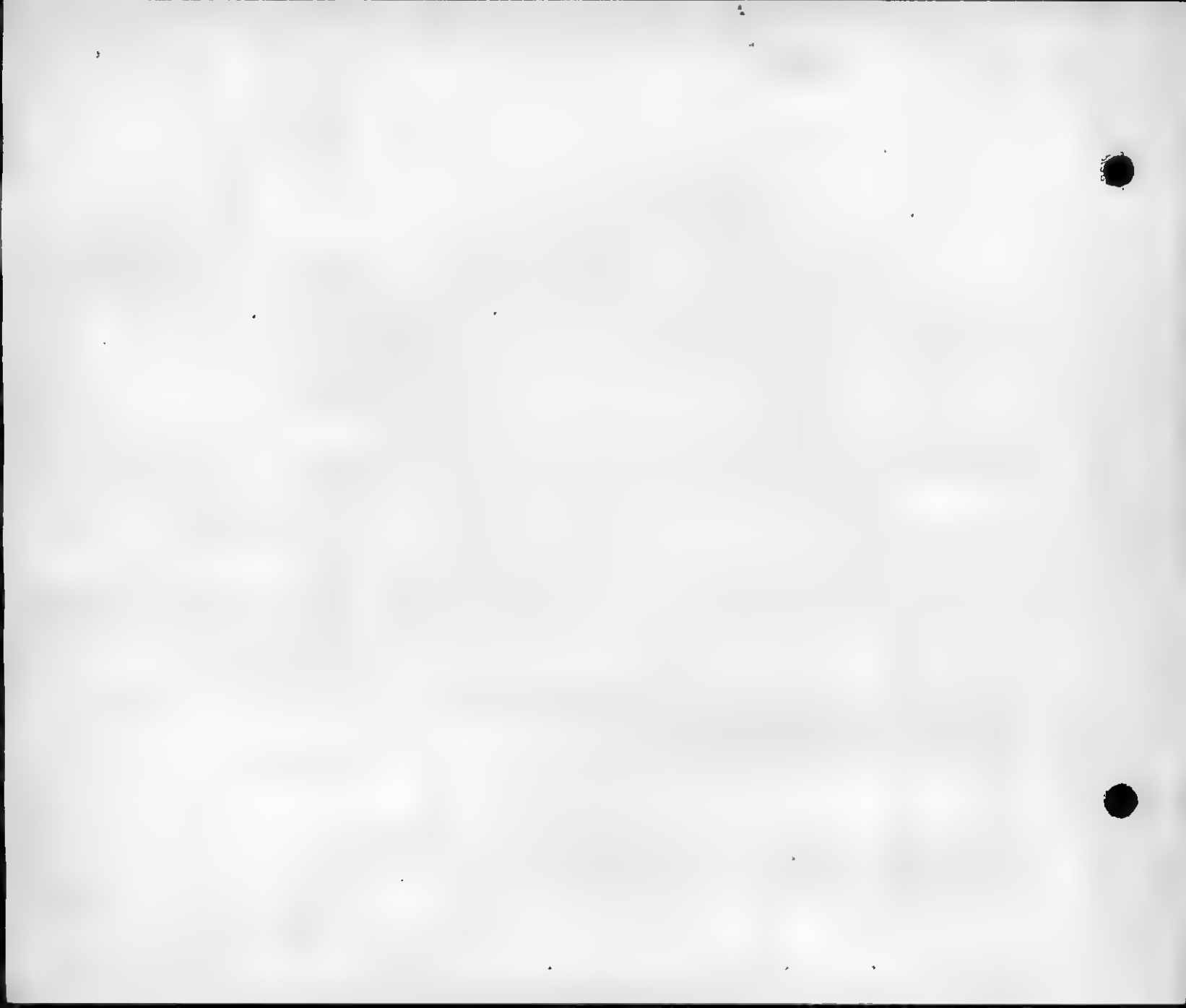
THIS MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Reg. Dist. No. 302													
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 5</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>										f. STREET ADDRESS <u>Leitersburg</u>		* IS KEY DEPENDENT ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ESTHER KUHN BAUMGARDNER</u>						4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1959</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14 1897</u>		9. AGE (In years last birthday) <u>61 yrs</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS Hours <u> </u> Mins. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Kuhn</u>						14. MOTHER'S MAIDEN NAME <u>Mary Hanburg</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Frank B. Baumgardner</u> Address <u>Hagerstown R #5</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined / pending Autopsy report</u> <u>970.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Poisoning due to overdose of Potassium Thiocyanate</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Took over dose of Blood pressure pills</u>									
20c. TIME OF INJURY Month, Day, Year Hour <u>XXX</u> <u>Noon</u> p. m. <u>4-26-59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>at home</u>		20f. (City or town) <u>Hagerstown</u>		(County) <u>Wash</u>		(State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>													
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>4-27-59</u>					
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Waynesboro Franklin Co Pa</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>						ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

04806

Reg. Dist. No. 302



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4880

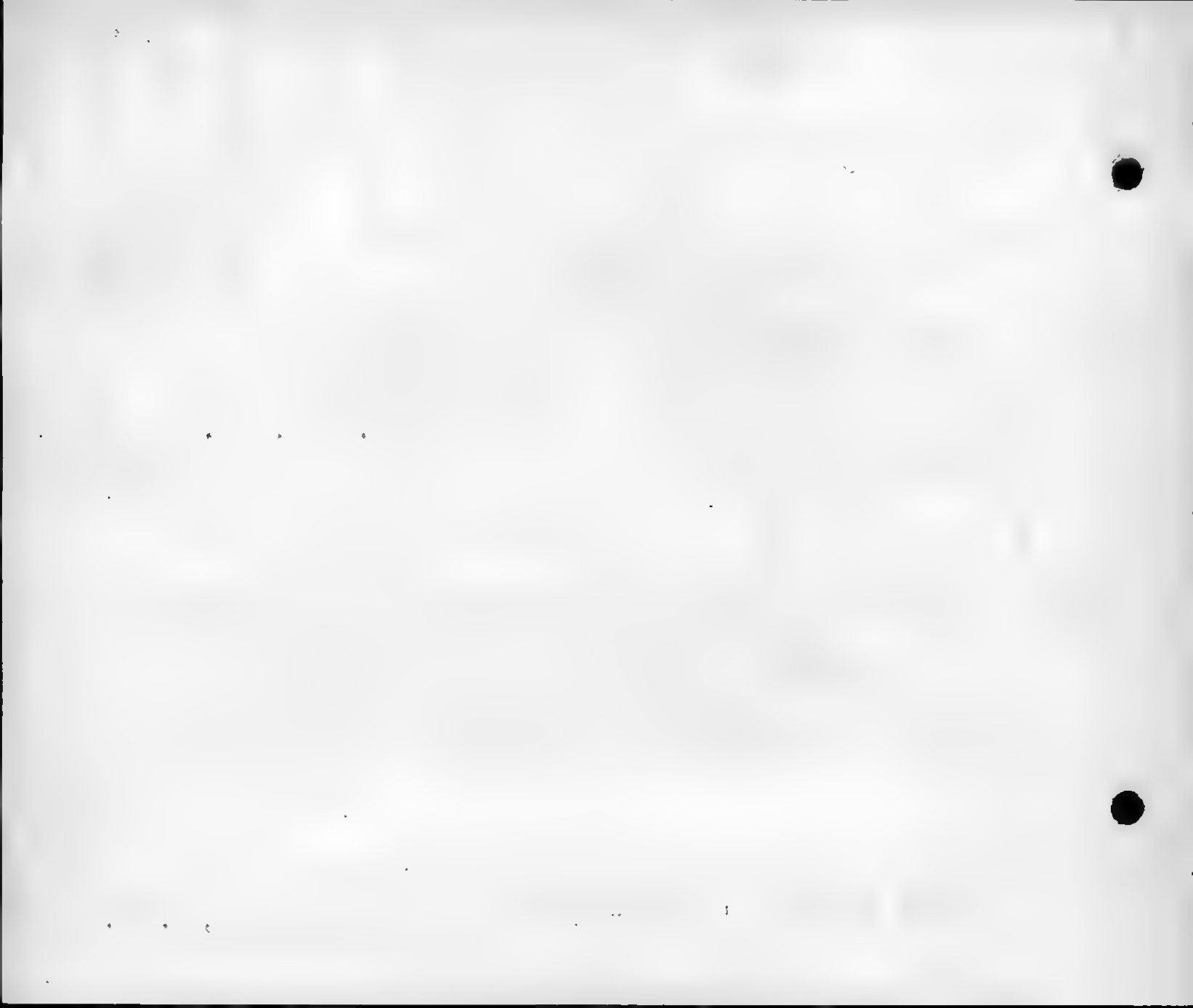
CERTIFICATE OF DEATH

04807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Putnam</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>2245 Tennessee H.e.</u>			
3. NAME OF DECEASED (Type or print) <u>Catherine Reeser Blondel</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5, 1858</u>		9. AGE (In years last birthday) <u>104 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>14</u> Days <u>19</u> Hours <u>59</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gerhart</u>				14. MOTHER'S MAIDEN NAME <u>Emmeline Reeser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Catherine Reeser</u> Address <u>224 S. Tenn. Ave. Martinsburg, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Cardiovascular system</u> DUE TO (c) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>29 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 9, 1958</u> to <u>April 14, 1959</u> , that I last saw the deceased alive on <u>April 14, 1959</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert L. Leaf</u>				ADDRESS (Street, city or town, state) <u>Williamsport, Md.</u> DATE SIGNED <u>April 14, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Albert L. Leaf</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 17, '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				24a. REC'D BY REGISTRAR <u>APR 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4819

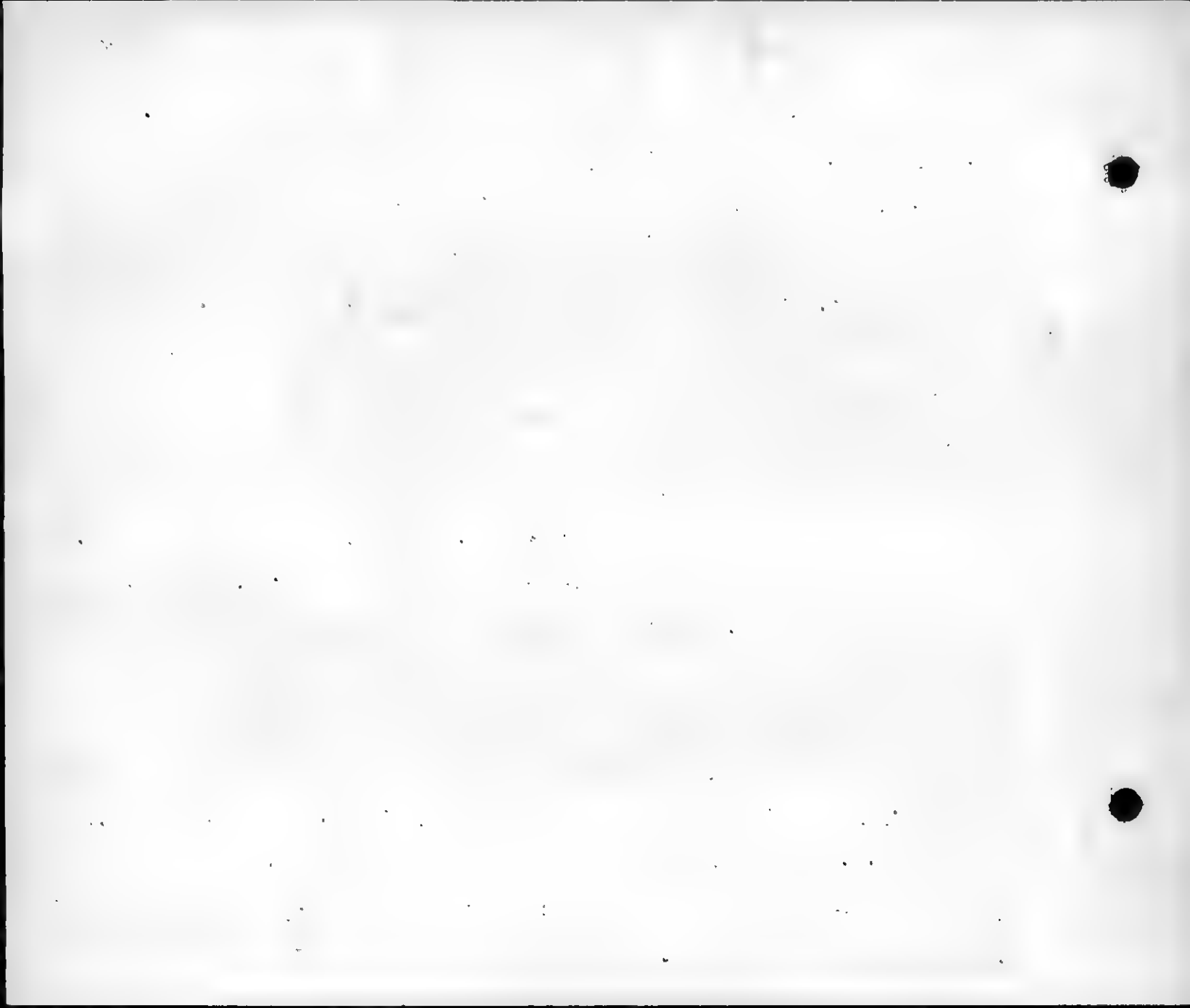
CERTIFICATE OF DEATH

04808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i> 12-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Western Md. State Hospital</i>		d. STREET ADDRESS <i>553 Girard street</i>	
3. NAME OF DECEASED (Type or print) First <i>ETHEL</i> Middle <i>(unknown)</i> Last <i>Boston</i>		4. DATE OF DEATH Month <i>April</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 4, 1890</i>
9. AGE (In years last birthday) <i>68</i> yrs		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>maid</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>Will Stansbury</i>		14. MOTHER'S MAIDEN NAME <i>Martha Frederick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>Patient</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia, bilateral</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) <i>Pulmonary edema and congestion</i> DUE TO (c) <i>arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 days</i> <i>several years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>① Hypertension, essential ② cerebral sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 4, 1959</i> , to <i>April 20, 1959</i> , that I last saw the deceased alive on <i>April 20, 1959</i> , and that death occurred at <i>2:45 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Victor L. Ramos</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Western Md. State Hospital April 20, 1959</i>	
PHYSICIAN'S NAME (Type) <i>Victor L. Ramos</i>		<i>Hagerstown, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/25/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Harre de Grace Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullink</i>		24a. REC'D BY REGISTRAR DATE <i>APR 28 '59</i>	
ADDRESS <i>Harre de Grace, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4881

CERTIFICATE OF DEATH

04809

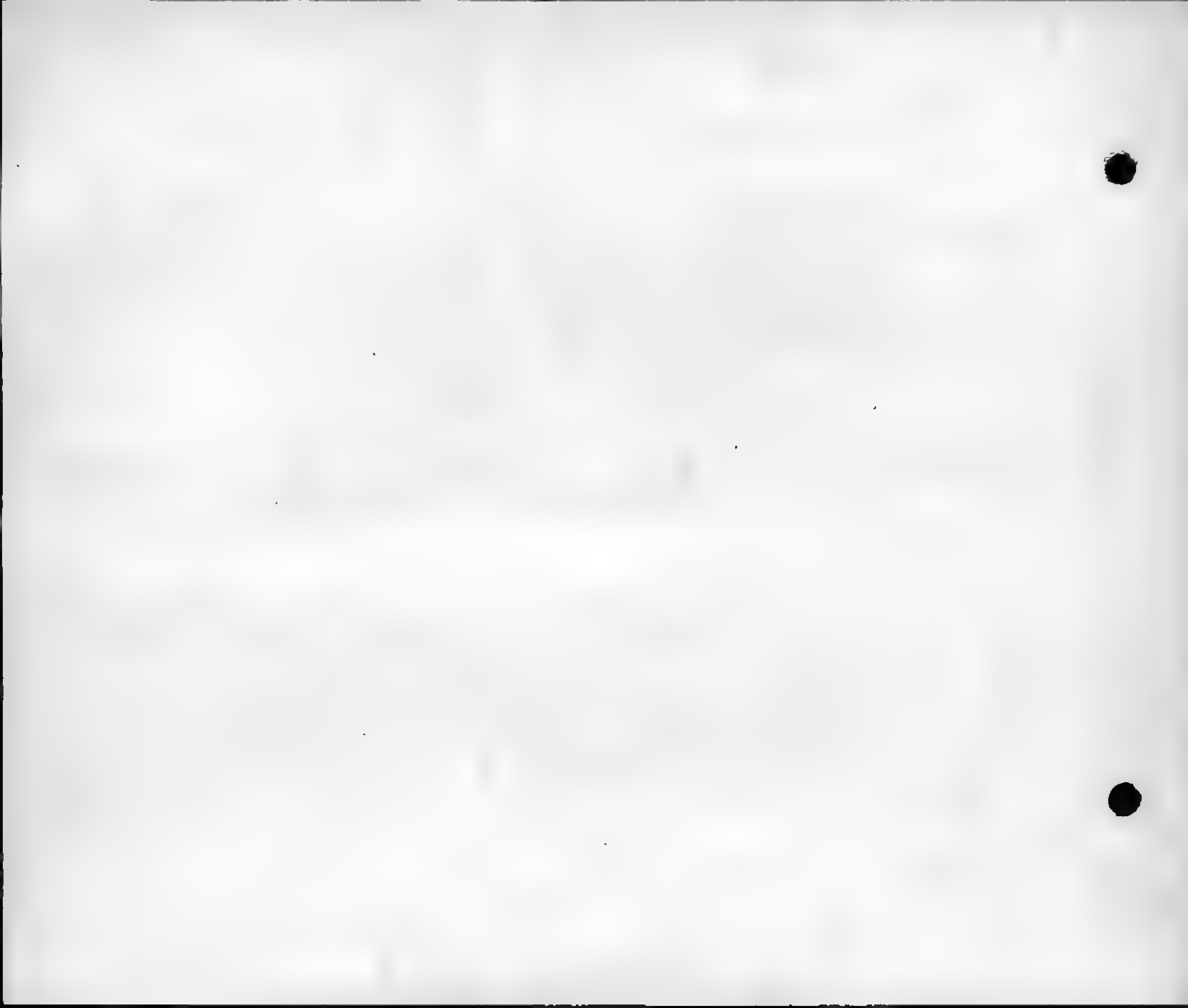
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRPLAY RURAL c. LENGTH OF STAY IN 1b LIFE		2. USUAL RESIDENCE (Where deceased lived) II Institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRPLAY RURAL d. STREET ADDRESS FAIRPLAY MD. R. 1 (RICHARD ROAD)	
3. NAME OF DECEASED (Type or print) GEORGE WASHINGTON SHOWMAN BOYER First Middle Last		4. DATE OF DEATH APRIL - 16, 1959 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 31 - 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) TAYLORS LANDING WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES E. BOYER		14. MOTHER'S MAIDEN NAME ANNA CATHERINE ARTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. HARRIET SHOWMAN FAIRPLAY MD. R. 1		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.1 DUE TO Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/15-19 19 59 , to 4/16/59 19 59 , that I last saw the deceased alive on 4/16/59 19 59 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED DR. J. H. Young M.D. Williamsport Md 4/17/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 19, 1959	
22c. NAME OF CEMETERY OR CREMATORY MT. VIEW CEMETERY		22d. LOCATION (City, town, or county) (State) SHARPSBURG WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Best - BOONSBORO MD.		24a. REC'D BY REGISTRAR APR 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove page 3 and file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. YOUNG
C.A. 3 2 231



4820

CERTIFICATE OF DEATH

04810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB Since 3-11-59	
d. NAME OF HOSPITAL (If not in hospital, give street address) Western Maryland State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
f. NAME OF HOSPITAL (If not in hospital, give street address) Western Maryland State Hospital		d. STREET ADDRESS 108 East Fifth Street	
3. NAME OF DECEASED (Type or print) First MARLARET Middle BRUST Last BRUST		4. DATE OF DEATH Month APR. Day 2 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ephriam Fogle		14. MOTHER'S MAIDEN NAME Harriett Albaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Ethel B. Brust (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema + congestion			
154x DUE TO left, lower lobe			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Lobular pneumonia + small pulmonary embolus			
DUE TO Embolus			
(c) Carcinoma of rectum + pelvic metastasis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydronephrosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 11, 1959 to April 2, 1959 , that I last saw the deceased alive on April 2, 1959 , and that death occurred at 3:50 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Victor L. Ramos M.D. Western Md State Hospital April 2, 1959			
PHYSICIAN'S NAME (Type) VICTOR L. Ramos Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-59	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR APR 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

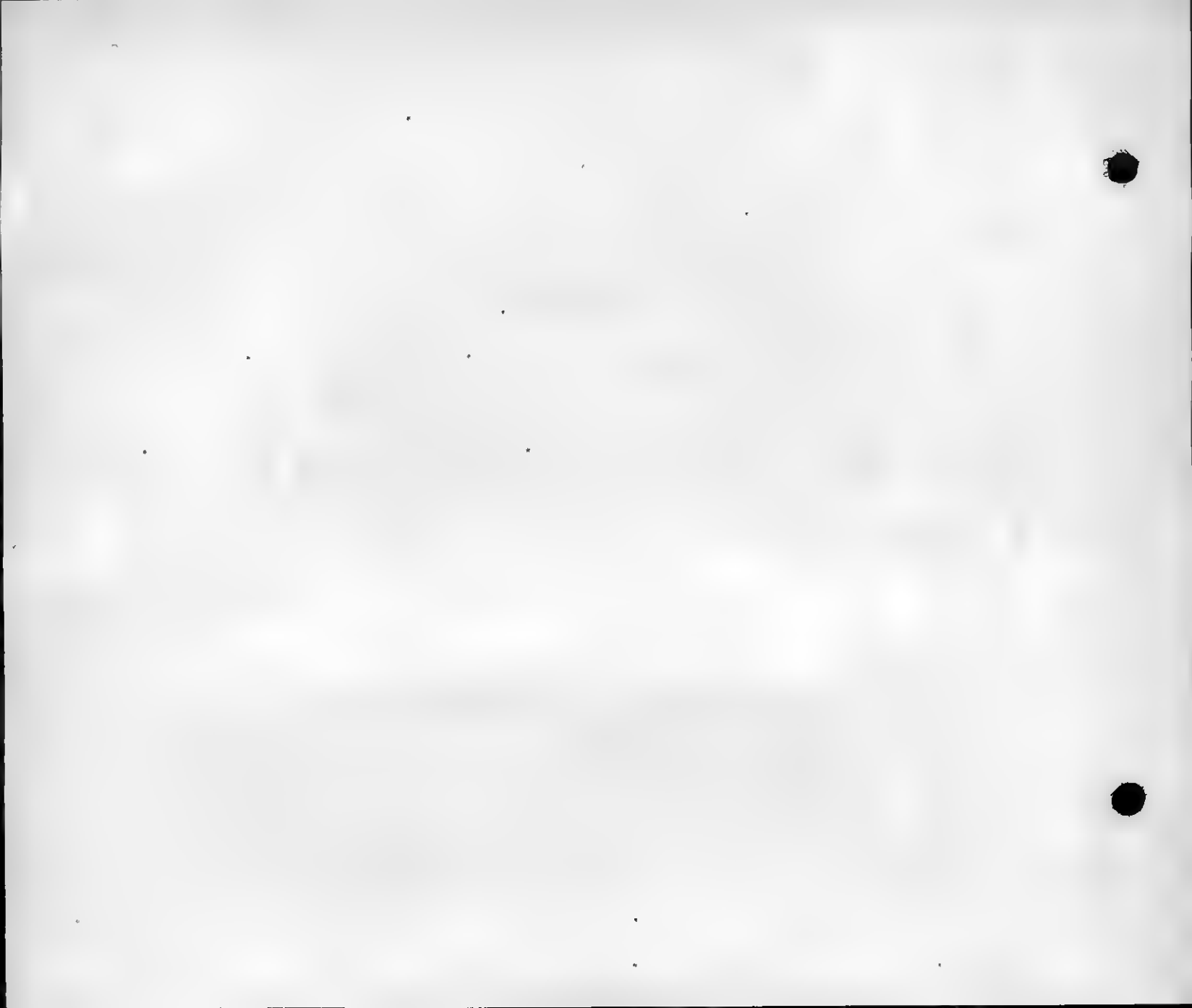
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1318 Glenwood Ave.,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1318 Glenwood Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sylvester J Buckler		4. DATE OF DEATH Month Day Year 4 18 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1912
9. AGE (In years last birthday) 47 yrs		10. IF UNDER 1 YEAR Manths Days Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) furniture finisher		10b. KIND OF BUSINESS OR INDUSTRY Brandts	
11. BIRTHPLACE (State or foreign country) St. Marys' County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isiah Buckler		14. MOTHER'S MAIDEN NAME Agnes Tippet Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-26-2139	
17. INFORMANT Mrs. Alice Buckler		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined pending autopsy report 9702 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute Phenobarbital Poisoning (a), stating the underlying cause last (c) Aspiration of vomitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Took over dose of Phenobarbital tablets	
20c. TIME OF INJURY Month, Day, Year Hour Minute 9:00 p m 4-17-59	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home	20f. (City or town) (County) (State) Hagerstown Wash Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-21-59	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Hagerstown Rural Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		24a. REC'D BY REGISTRAR DATE APR 22 '59	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hane	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be retained as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4822

CERTIFICATE OF DEATH

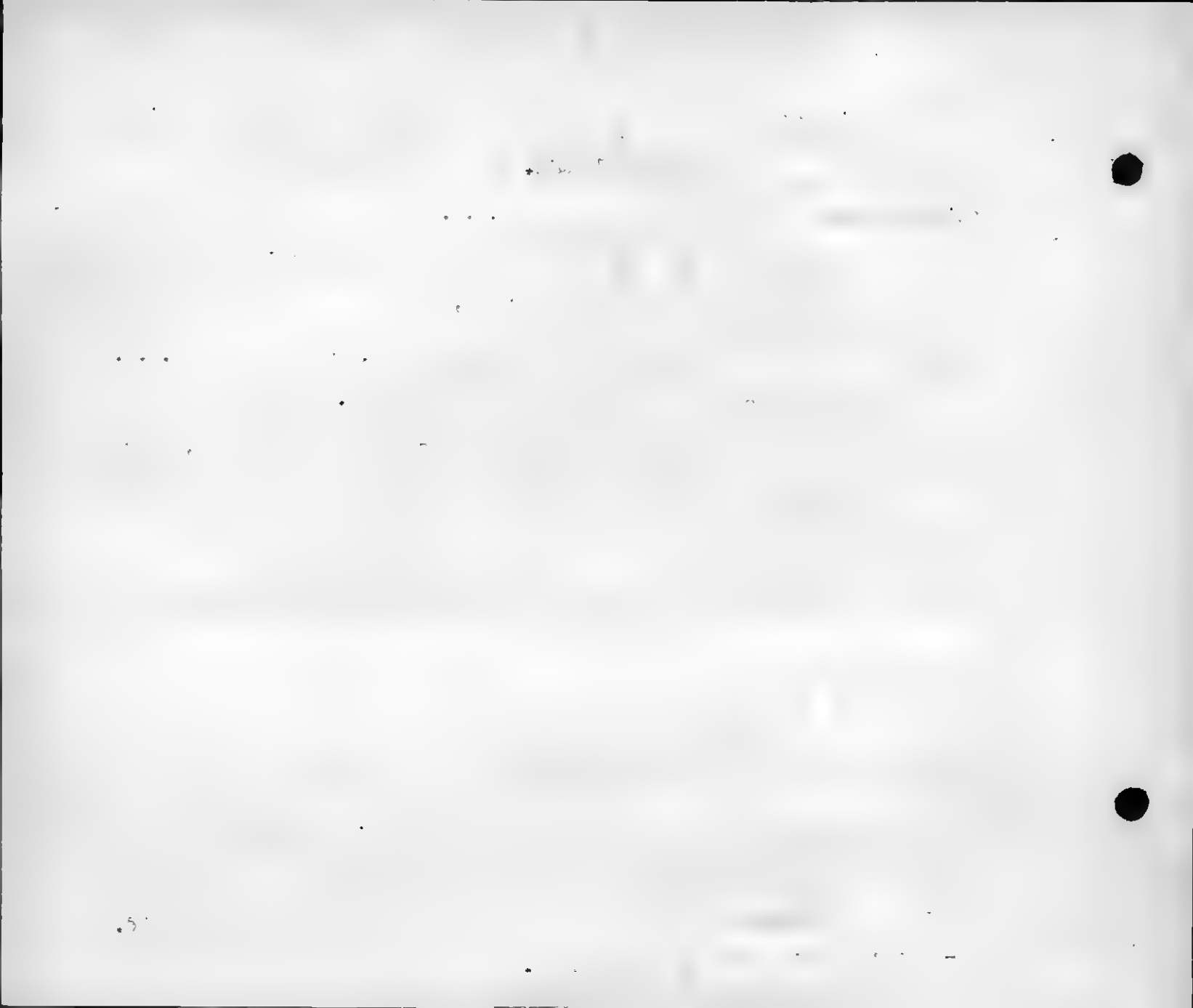
04812

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
c. LENGTH OF STAY IN TB 2 hours 15 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TERRY Middle LEE Last BUTTS		4. DATE OF DEATH Month April Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1959
9. AGE (In years last birthday) 2 yrs		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Butts		14. MOTHER'S MAIDEN NAME Frances L. Shank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Raymond Butts		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO allergic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immaturity DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 10, 1959 to April 10, 1959 , that I last saw the deceased alive on April 10, 1959 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. S. Dowe Jr.		DATE SIGNED 4/10/59	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/1959	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



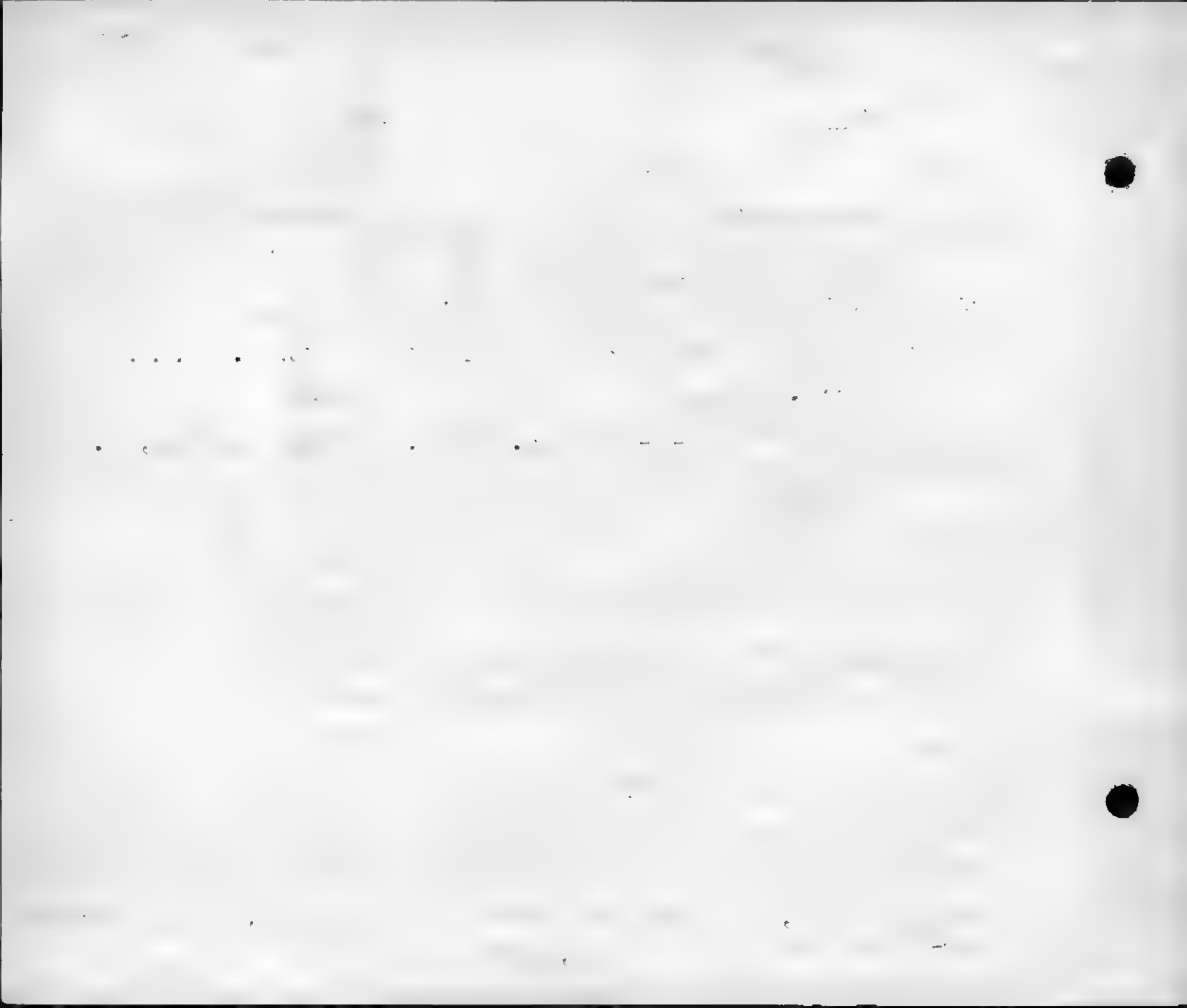
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial/cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2:57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4823 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04813
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 24 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 71 Nottingham Road		e. STREET ADDRESS 71 Nottingham Road	
3. NAME OF DECEASED (Type or print) ARCHIE OWEN CAUFFMAN		4. DATE OF DEATH Month April Day 15 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1909
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY School Board	
11. BIRTHPLACE (State or foreign country) Blue Ridge Summit, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur C. Cauffman		14. MOTHER'S MAIDEN NAME Jennie Nagle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-10-3019	
17. INFORMANT Mrs. Retha H. Cauffman		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 33/x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sp. 12/8	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. H. Beachley		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) J. H. Beachley		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/16/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/1959	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Maryland	
24a. REC'D BY REGISTRAR DATE APR 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4824 CERTIFICATE OF DEATH

04814

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 Mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. STREET ADDRESS <u>/ 921 A Main Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR DURMAN CHILDRESS</u>		4. DATE OF DEATH Month Day Year <u>April 16 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 14 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Holland Furnace</u>	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick H. Childress</u>		14. MOTHER'S MAIDEN NAME <u>Martha (no record)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-8875</u>	
17. INFORMANT Address <u>Lrs Essie V. Childress 921 A Main Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> DUE TO <u>Carcinoma Prostate & Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Granulosa Cell Carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-1-58</u> to <u>4-16-59</u> , that I last saw the deceased alive on <u>4-13-59</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u> DATE SIGNED <u>4/18/59</u>			
ACTUAL SIGNATURE <u>A. K. Coffman</u> M.D.		FURNEL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. RECEIVED BY REGISTRAR <u>APR 21 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Thayer</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04815

Reg. Dist. No.

4882

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport,			c. LENGTH OF STAY IN 1b 28 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 2				d. STREET ADDRESS / R # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Franklin Last Clark				4. DATE OF DEATH Month April Day 20 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-24-73		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming -Self		11. BIRTHPLACE (State or foreign country) Wash. County		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Clark				14. MOTHER'S MAIDEN NAME Mary Jane Harmon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-1271		17. INFORMANT Address David Anderson- R # 2 Williamsport, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis							
DU TO Arteriosclerotic coronary heart disease							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced generalized arteriosclerosis							
DU TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
none							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-20-59	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF APRIL-23-1959		22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) HAGERSTOWN WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Best				ADDRESS BOONSBORO MD.		24a. REC'D BY REGISTRAR DAVID R 4 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4825

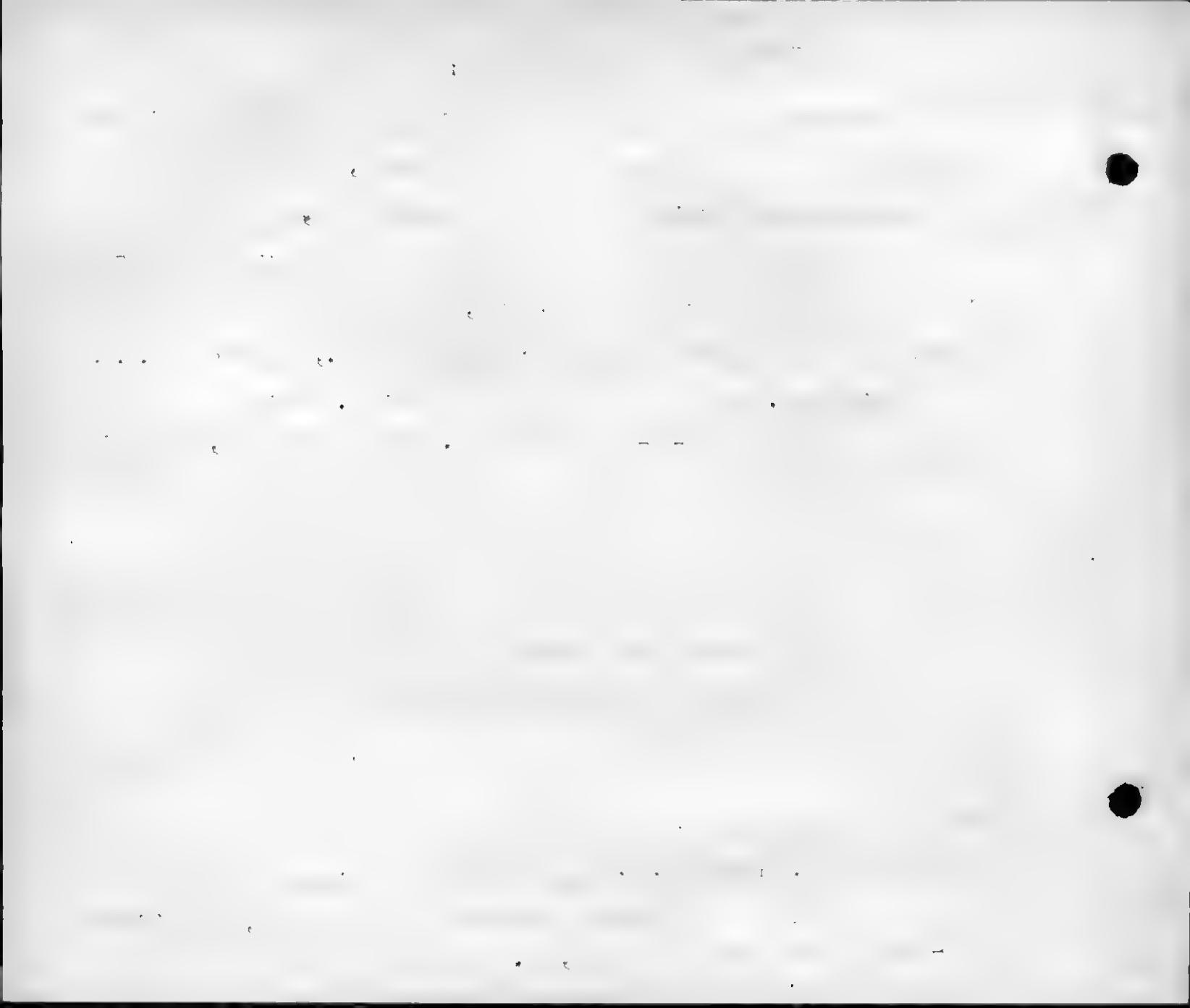
CERTIFICATE OF DEATH

04816

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 720 Potomac Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LUTHER GEORGE COSS		4. DATE OF DEATH Month April Day 7 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10b. KIND OF BUSINESS OR INDUSTRY Roofing contractor	
11. BIRTHPLACE (State or foreign country) Washington Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. Coss		14. MOTHER'S MAIDEN NAME Annie K. Justice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-2476	
17. INFORMANT William C. Coss		Address Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulm. emboli 41X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1-2 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arr. fibrillation, Cardiac failure		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 JUNE , 1958, to 7 APRIL , 1959, that I last saw the deceased alive on 6 APRIL , 1959, and that death occurred at 2:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard T. Binfard, M.D. 1135 POTOMAC AVENUE 7 APRIL, 1959			
ACTUAL SIGNATURE Richard T. Binfard		PHYSICIAN'S NAME (Type) RECHARD T. BINFORD, M. D. HAGERSTOWN, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/9/1959	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sutere-Ronzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE APR 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04817
Item 8 Film G241, 4/9/59 fcy										
4826										
CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH o. COUNTY WASHINGTON COUNTY Western Md. Hosp.					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.					c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md Hosp.					d. STREET ADDRESS 2644 Edmondson Ave					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DANIEL Middle WEBSTER Last COX					4. DATE OF DEATH Month APRIL Day 3 Year 1959					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13 1904		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer					10b. KIND OF BUSINESS OR INDUSTRY N.C.					11. BIRTHPLACE (State or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME Wright Cox					14. MOTHER'S MAIDEN NAME Mariah Cox
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. Ellen Dorden 2644 Edmondson Ave.					INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion & Edema 191.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Anus - Metastases DUE TO (c) Cerebral Vascular Accident										INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)										
21. I certify that I attended the deceased from MAR. 20 , 19 59 , to APR. 3 , 19 59 , that I last saw the deceased alive on APR. 3 , 19 59 , and that death occurred at 8:30 AM , from the causes and on the date stated above.										
ACTUAL SIGNATURE Evaristo R. Landry M.D.					ADDRESS (Street, city or town, state) 1500 Pennsylvania Ave					DATE SIGNED 4/3/59
PHYSICIAN'S NAME (Type) EVARISTO R. LANDRY, MD					Hagerstown, Ind.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried					22b. DATE THEREOF 4/8/59					22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
22d. LOCATION (City, town, or county) (State) Ann Arbor 1st County Ind										
23. FUNERAL DIRECTOR'S SIGNATURE Holstead-Morley					ADDRESS 928 E. North Ave.					24a. REC'D BY REGISTRAR APR 7 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna										

MEDICAL CERTIFICATION

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4883

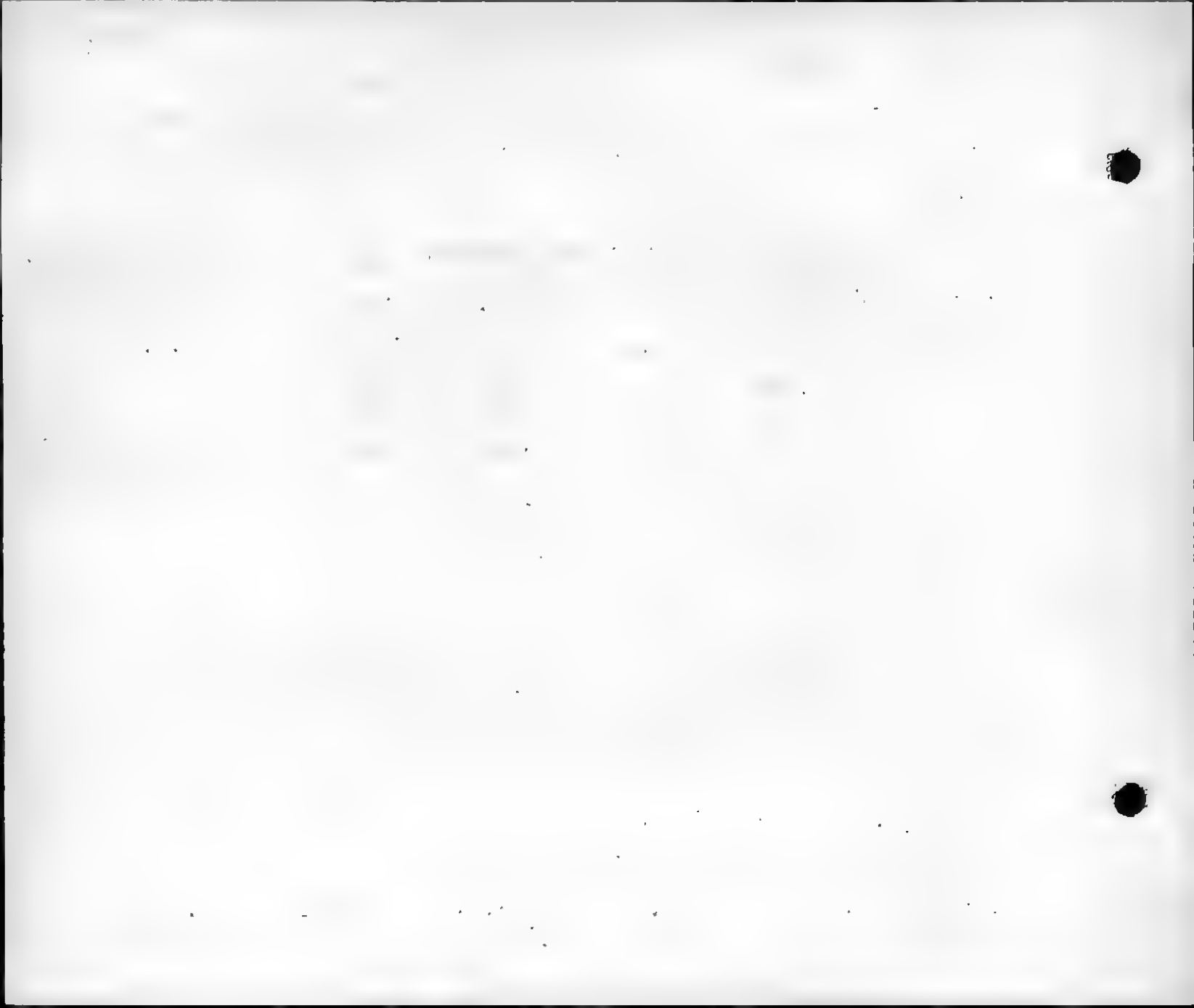
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairplay Md RFD #1				c. LENGTH OF STAY IN 1b 15 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) Fairplay				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Reba Middle Elizabeth Last Crampton				4. DATE OF DEATH Month April Day 14 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28 1888		9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months 3 Days 16 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry Swain				14. MOTHER'S MAIDEN NAME Anna Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Name Mr. Oliver Crampton Address Fairplay Md RFD #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 4/13/59 to 4/14/59	
21. I certify that I attended the deceased from 4/13/59 19 to 4/14/59 19, that I last saw the deceased alive on 4/14/59 and that death occurred at 6:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Fairplay Md 4/15/59							
ACTUAL SIGNATURE Robert F. Smith		M.D. William F. Smith					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL, or other disposition Burial		22b. DATE THEREOF April 17-59		22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clara K. Smith				ADDRESS 218 W. Main St. Md		24a. REC'D BY REGISTRAR DATE APR 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.



4827

CERTIFICATE OF DEATH

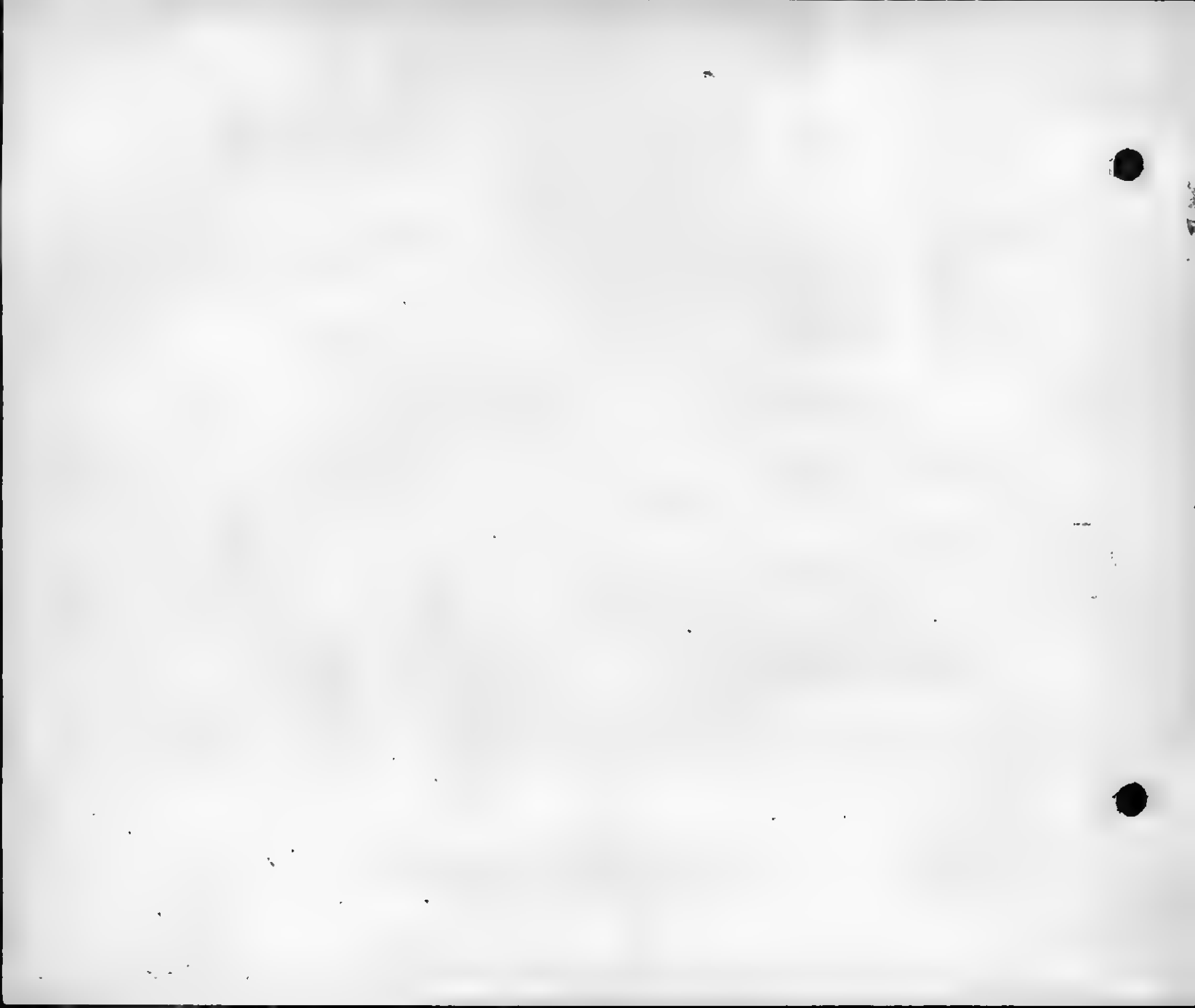
04819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		10-11-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md State Hospital</u>		d. STREET ADDRESS <u>406 BROADWAY</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle <u>CROMWELL</u> Last <u>CROMWELL</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1959</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>COLOR</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 7 1882</u>
9 AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MOSES CROMWELL</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE FRYE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT Address <u>UNKNOWN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 420.1 DUE TO <u>ESSENTIAL VASCULAR HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>UNKNOWN</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY ATHEROSCLEROSIS, CEREBRAL THROMBOSIS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 6</u> , 19 <u>59</u> , to <u>APRIL 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>APRIL 9</u> , 19 <u>59</u> , and that death occurred at <u>7:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Evaristo R. Laddizabal</u> M.D.		ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE</u>	
PHYSICIAN'S NAME (Type) <u>Evaristo R. Laddizabal</u>		DATE SIGNED <u>4-10-59</u>	
22a. DATE OF BURIAL, CREMATION, REMOVAL (Specify) <u>4-13-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Board of Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04820

4828

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN lb <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN Md STATE Hospital</u>		e. STREET ADDRESS <u>Catholic church Rd. Rt. 340</u>	
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Luther</u> Last <u>DANNER</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1959</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 19, 1895</u>
9. AGE (In years last birthday) yrs. <u>63</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Joseph DANNER</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Daffell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Hospital</u> Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Confluent Lobular pneumonia, bilateral</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple lung abscess, left lower lobe</u> DUE TO (c) <u>Bronchiectasis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>6 WEEKS</u> <u>UNKNOWN</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMPHYSEMA</u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 10</u> , 19 <u>59</u> , to <u>April 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>59</u> and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Evaristo R. LaRocca</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>500 PENNSYLVANIA AVE 4-27-59</u>	
FITSCHIAN'S NAME (Type) <u>Evaristo R. LaRocca</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF <u>4-29-59</u>	22c. NAME OF EMPLOYER OR CREMATORY <u>BURIAL HOME</u>	22d. LOCATION OF BURIAL, CREMATION, OR REMOVAL <u>BURITTSVILLE, Md</u> (State) <u>MD</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>B Lee Flete</u> Address <u>Brunswick Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1108 Carroll Hgts. Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Duffey		4. DATE OF DEATH Month 4 Day 26 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 74	11. IF UNDER 24 HRS. Days 74 Hours 74 Min 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Southern Shoe Co.	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Duffey		14. MOTHER'S MAIDEN NAME Elizabeth Sayles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-3797	
17. INFORMANT George Knott		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-abdominal, cervical, and pulmonary metastasis 200.1 200.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lymphosarcoma, left inguinal region (c) Arteriosclerotic & Hypertensive cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic & Hypertensive cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 6 wks. 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 3, 1958 , to April 26, 1959 , that I last saw the deceased alive on April 26, 1959 , and that death occurred at 7:45 P. M. from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) 100 Professional Arts Bldg. DATE SIGNED 4/27/59			
ACTUAL SIGNATURE William T. Layman M.D.		DATE SIGNED 4/27/59	
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4-29-59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE APR 29 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4830

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04822

Reg. Dist. No. 302

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 Yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1033 Main Ave		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MATTIE CHRISTMAS OCKER DYE		4. DATE OF DEATH Month April		Day 24		Year 1959		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 25 1892		9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 6		11. IF UNDER 24 HRS Days 19		12. IF UNDER 24 HRS Hours 19		13. IF UNDER 24 HRS Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Eaton		14. MOTHER'S MAIDEN NAME Mary Clem		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO -----		17. INFORMANT John J. Ocker 77 Devonshire Rd		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH minutes					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO (b) Acute cerebral hemorrhage		DUE TO (c) 331X		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year None 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None		(County) None		(State) None	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE S. Robert Wells		M.D. S. Robert Wells, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-25-59		22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		25. DEPUTY MEDICAL EXAMINER'S SIGNATURE Arthur S. Kline		26. DEPUTY MEDICAL EXAMINER'S SIGNATURE Arthur S. Kline		27. DEPUTY MEDICAL EXAMINER'S SIGNATURE Arthur S. Kline		28. DEPUTY MEDICAL EXAMINER'S SIGNATURE Arthur S. Kline		29. DEPUTY MEDICAL EXAMINER'S SIGNATURE Arthur S. Kline		30. DEPUTY MEDICAL EXAMINER'S SIGNATURE Arthur S. Kline		31. DEPUTY MEDICAL EXAMINER'S SIGNATURE Arthur S. Kline		32. DEPUTY MEDICAL EXAMINER'S SIGNATURE Arthur S. Kline					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04823

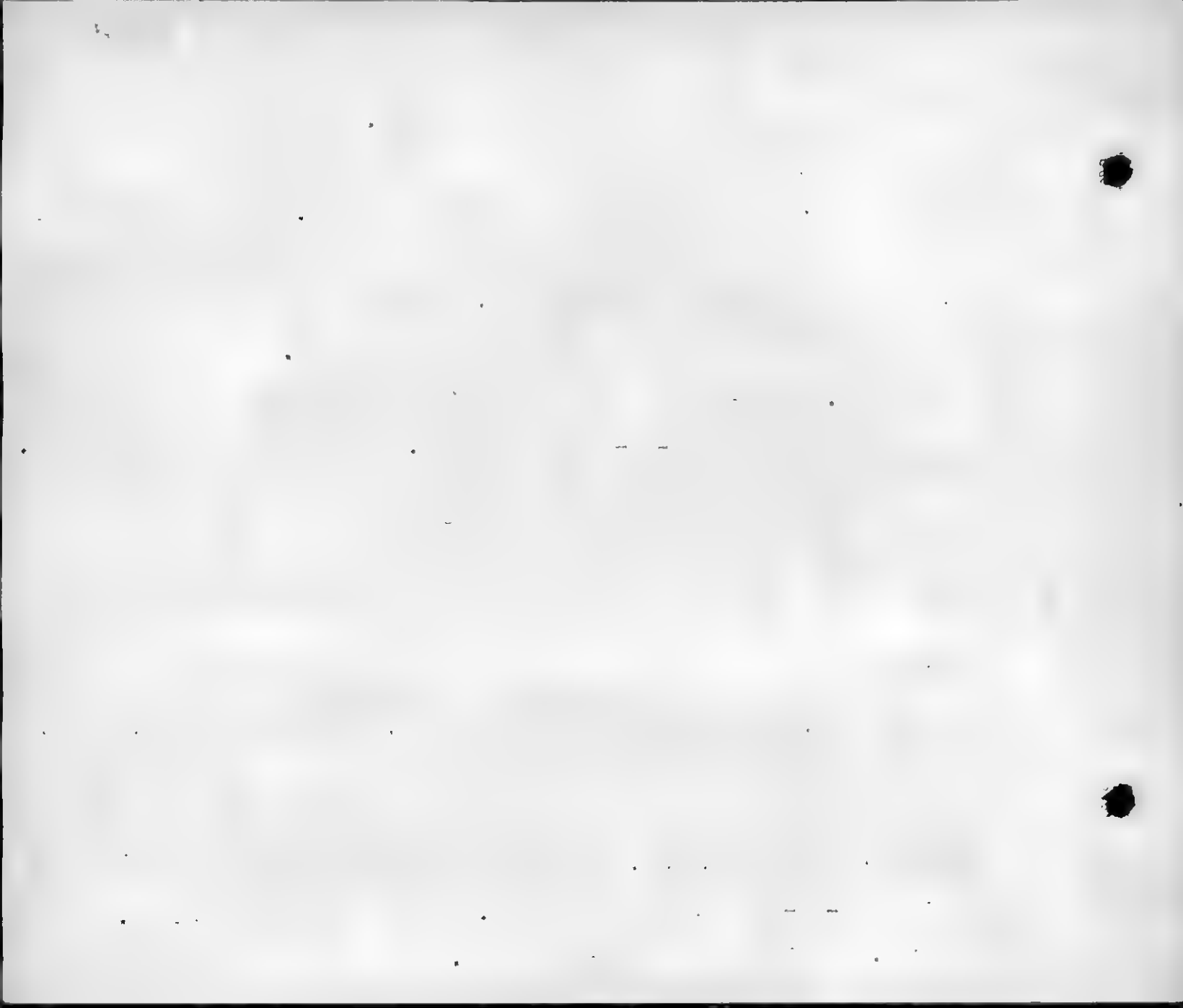
4831

Reg. Dist. No

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Cambria</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Johnstown</u> <u>7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>321 Penrod St.</u>	
3. NAME OF DECEASED (Type or print) <u>David</u> <u>John</u> <u>Eastlake</u>		4. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29 1940</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>18</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Johnstown Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Raymond C. Eastlake</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Blickenstaff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>183-30-5370</u>	
17. INFORMANT <u>Raymond C. Eastlake</u>		Address <u>Johnstown Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured pelvic bones</u> <u>816X</u> DUE TO <u>Fractured Femur (left-open)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured bladder and diaphragm</u> DUE TO (c) <u>Pneumonia (terminal)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>14hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Driving automobile and collided with cement truck</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:40</u> <u>Apr. 7 19 59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Jefferson Blvd.</u>	20f. (City or town) (County) (State) <u>Hagerstown</u> <u>Wash.</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>April 12 1959</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Type) <u>Burial</u>	22b. DATE THEREOF <u>4-15-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Johnstown Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>		24a. REC'D BY REGISTRAR <u>DATE APR 15 '59</u>	
ADDRESS <u>Hagerstown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

DEATH CERTIFICATE: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



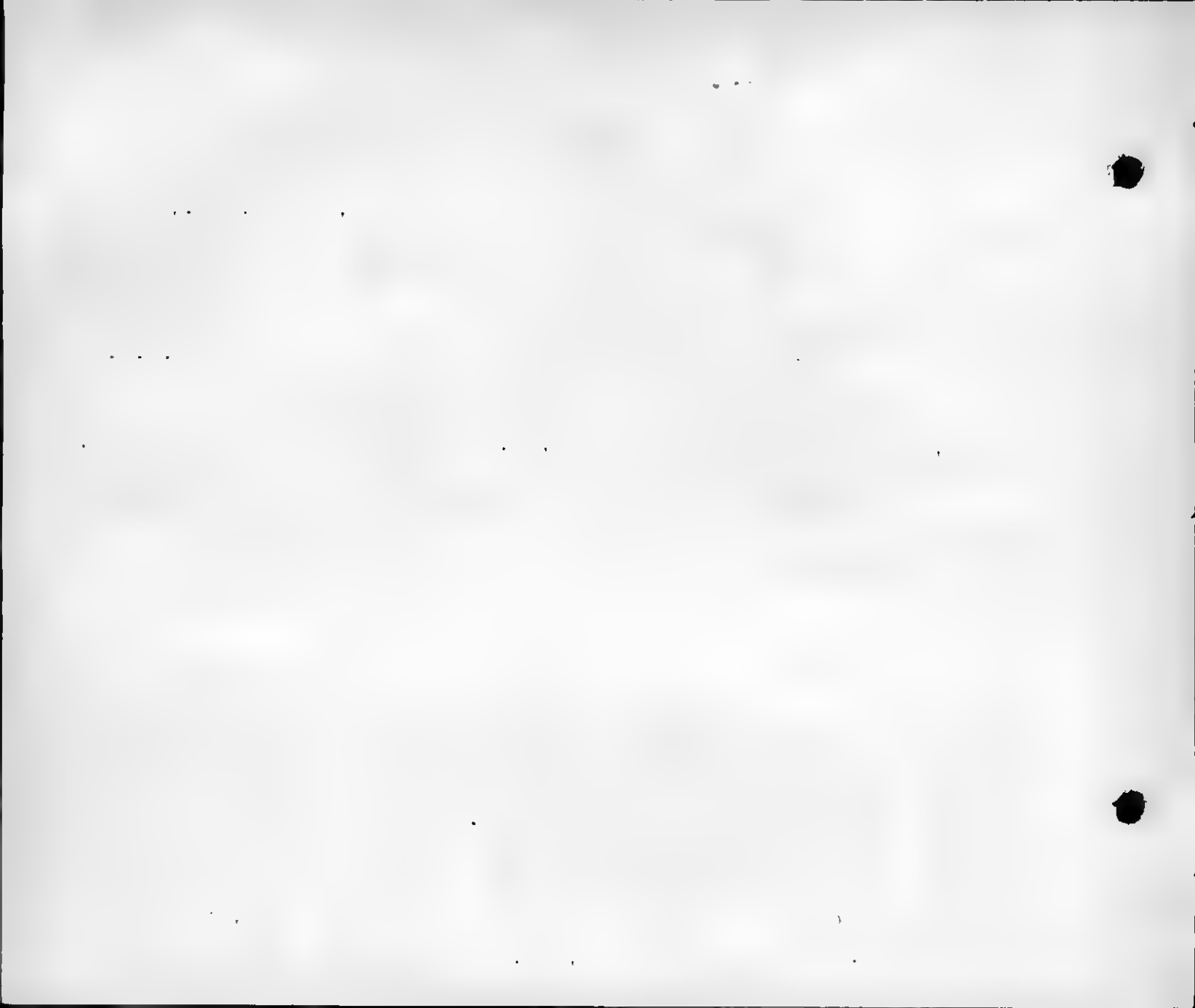
4884

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>0</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>5 wks 4 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. STREET ADDRESS <u>Windsor Hotel, Balto. St.,</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES Franklin EYMAN</u>				4. DATE OF DEATH Month Day Year <u>April 26 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1866</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours M.in.		11. IF UNDER 24 HRS. Months Days Hours M.in.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Proprietor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>			
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Eyman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wayne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. C. Wayne Eyman Pittsburg, Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infectious Hepatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>092x</u> DUE TO (c) <u>4 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Refractile Anemia — Cystitis (Chronic)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 1, 1958</u> to <u>April 26, 1959</u> , that I last saw the deceased alive on <u>April 24, 1959</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M E Byrkit</u> M.D. <u>28 W Potomac</u>				ADDRESS (Street, city or town, state) <u>4-26-59</u>			
PHYSICIAN'S NAME (Type) <u>Max E. Byrkit</u>				LOCATION (City, town, or county) (State) <u>Williamsport Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



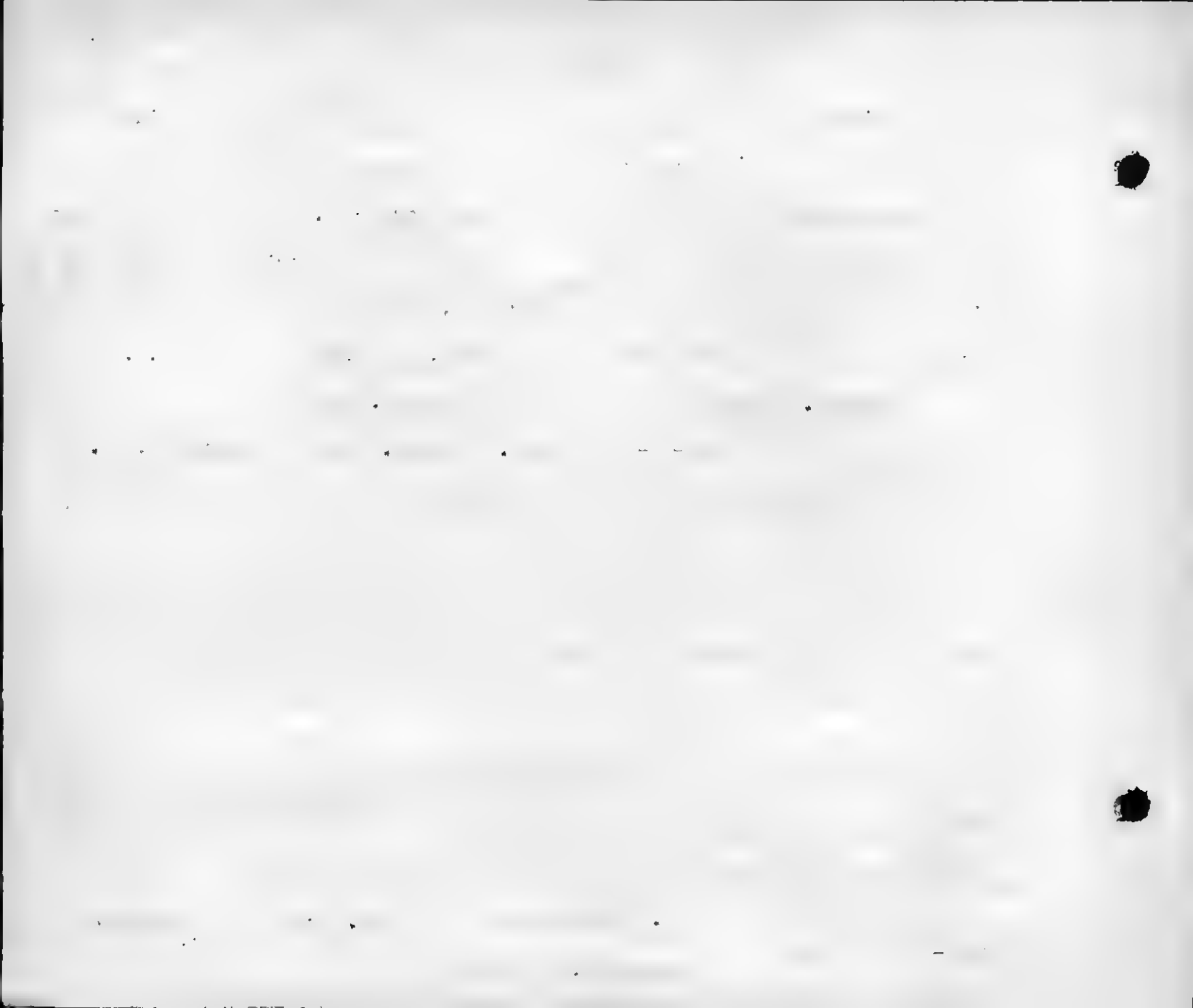
4832

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 49 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 North Avenue		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 120 North Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAURA First RAGAN Middle FOCKLER Last 4. DATE OF DEATH April Month 13 Day 19 59 Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 15, 1890 9. AGE (In years last birthday) 68 yrs IF UNDER 1 YEAR: Months 68 Days 13 Hours 19 Min 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady 10b. KIND OF BUSINESS OR INDUSTRY meat Market 11. BIRTHPLACE (State or foreign country) Wilson, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George S. Fockler 14. MOTHER'S MAIDEN NAME Laura K. Mitchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO 214-09-1883 17. INFORMANT Miss. Bessie M. Fockler Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Heart Disease. 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. _____ p. m. _____ 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from Aug. 18, 1956 to Apr. 13, 1959 that I last saw the deceased alive on April 13, 1959 and that death occurred at 7:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 North Potomac St. Maryland DATE SIGNED 4-14-59			
ACTUAL SIGNATURE R.A. Bell PHYSICIAN'S NAME (Type) R.A. Bell, M.D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/16/1959 22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery 22d. LOCATION (City, town, or county) St. Paul Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Super-Houser Funeral Home ADDRESS Hagerstown, Maryland 24a. REC'D BY REGISTRAR APR 16 '59 24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4833

CERTIFICATE OF DEATH

04826

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN TB 1/2 hour		d. STREET ADDRESS 712 Guilford Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 29* East Franklin Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HORACE CLAY FOGLE		4. DATE OF DEATH April 27 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1915
9. AGE (In years last birthday) 43 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Thurmont, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy I. Fogle		14. MOTHER'S MAIDEN NAME Miriam E. Foreman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) yes		16. SOCIAL SECURITY NO. W.W. II 266-36-0220	
17. INFORMANT Mrs. Dorothy Fogle		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH minutes 744.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 10-31 , 19 55 , to 4-27 , 19 59 , that I last saw the deceased alive on 4-25 , 19 59 , and that death occurred at 8 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE Lloyd A. Hoffman M.D.		DATE SIGNED (4-27) ADDRESS (Street, city or town, state) 214 N. Potomac St. 4/27/59	
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		Hagerstown, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/29/1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Maryland	
24a. REC'D BY REGISTRAR DATE APR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4834

CERTIFICATE OF DEATH

04827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 Month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				e. STREET ADDRESS 1220 Wabash Avenue			
3. NAME OF DECEASED (Type or print) First Samuel Middle Henry Last Fowler Jr				4. DATE OF DEATH Month April Day 14 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1902	9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min 56	IF UNDER 24 HRS Months 56 Days 56 Hours 56 Min 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Downsville, Wash. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel H. Fowler, Sr.				14. MOTHER'S MAIDEN NAME Rose Anna King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 220-05-6828		INFORMANT Address Mrs. Irene C. Fowler, 1220 Wabash Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) confluent lobular pneumonia, rt. lung 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of the larynx with regional metastasis DUE TO (c) metastasis						INTERVAL BETWEEN ONSET AND DEATH 4 days 9 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 14, 1959 , to April 14, 1959 , that I last saw the deceased alive on April 14, 1959 , and that death occurred at 12:02 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Victor L. Ramos M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Western Md. State Hospital April 14/59			
PHYSICIAN'S NAME (Type) Victor L. Ramos				Hagerstown, Maryland			
22a. BURIAL, CREMAT., OR REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/59		22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville, Wash. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR APR 17 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4835

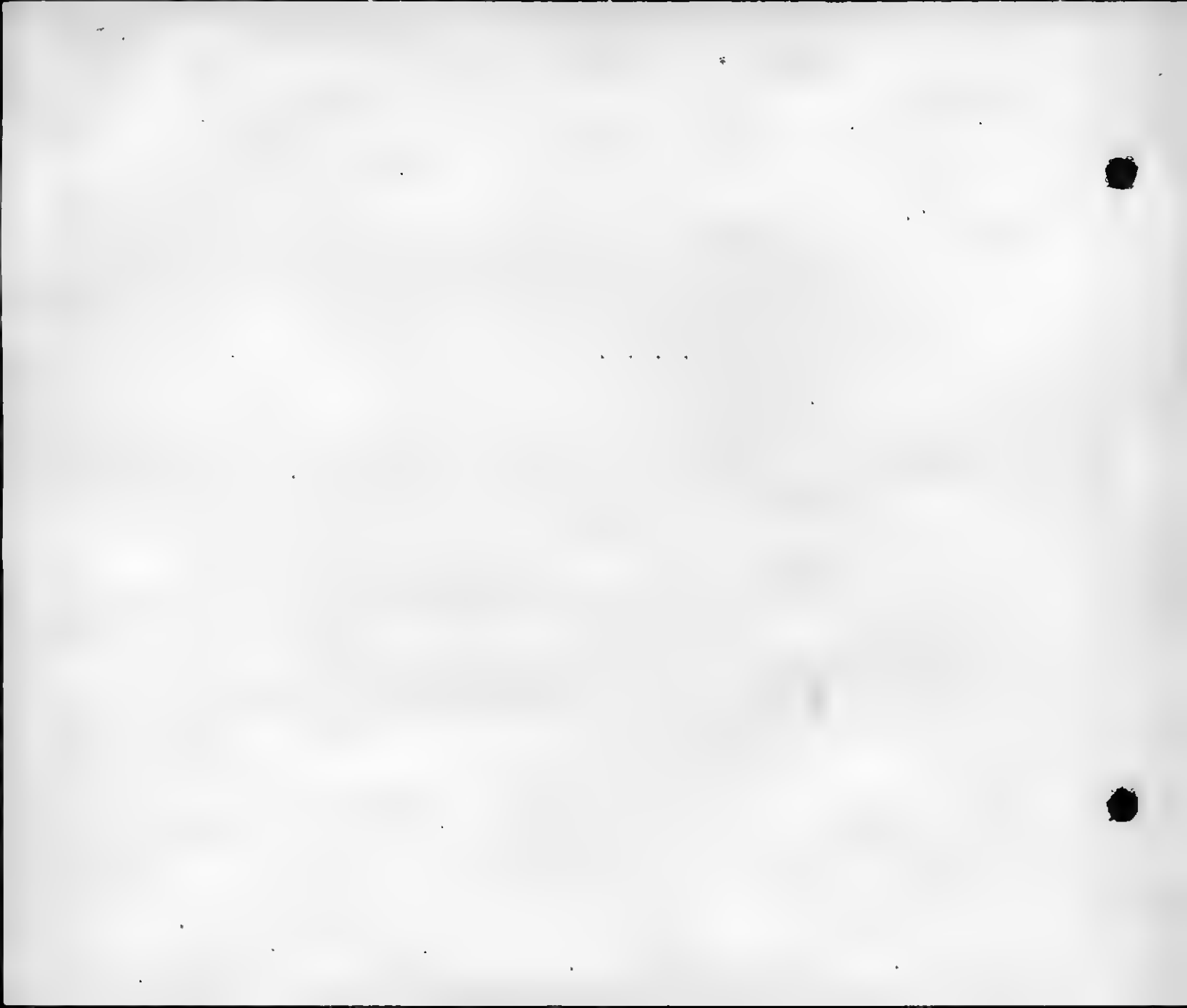
CERTIFICATE OF DEATH

04828

Reg. Dist. No. 302

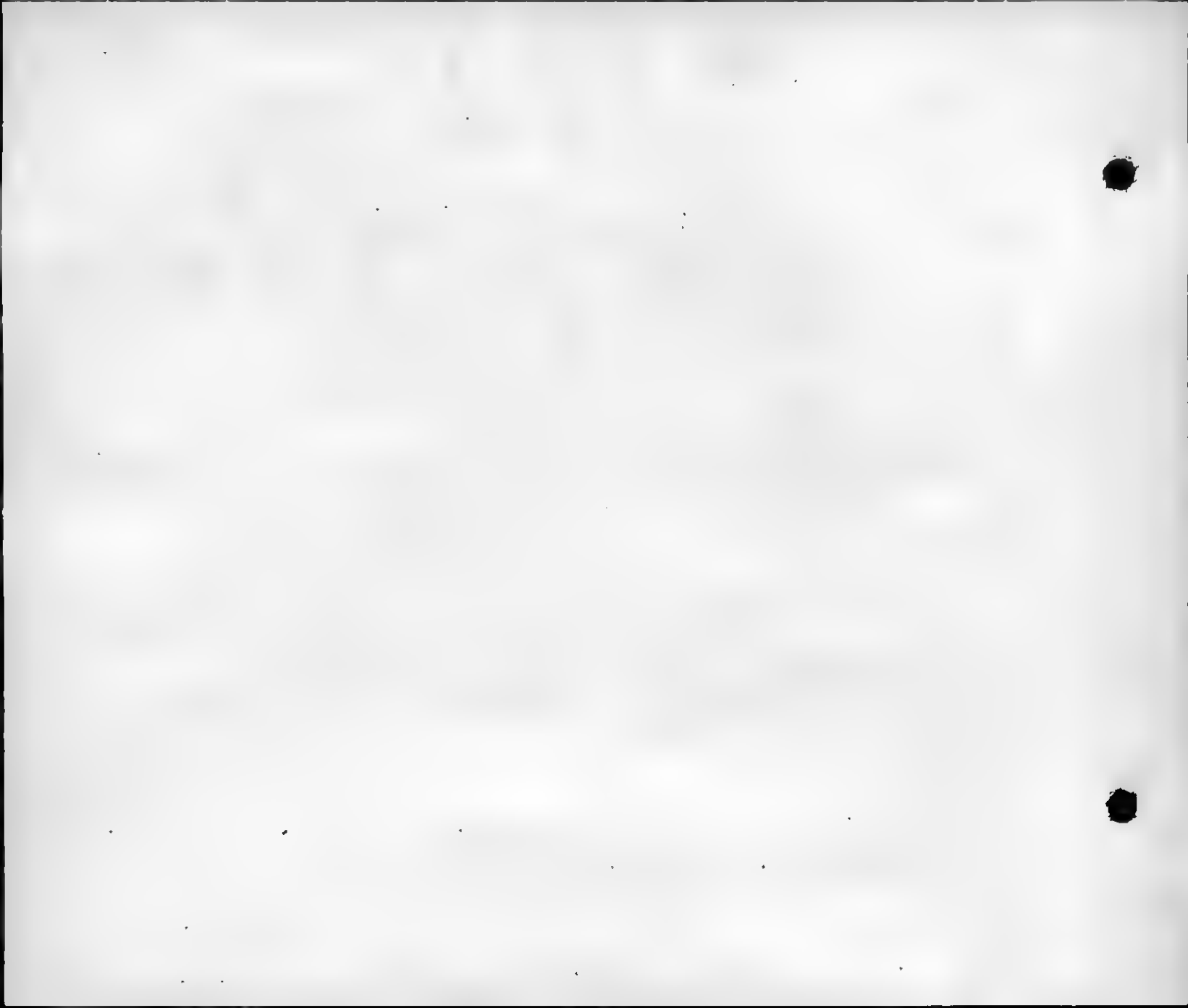
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>141 West Franklin St</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>ELLSWORTH</u> Last <u>FRANK Sr</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6 1893</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>	11. IF UNDER 24 HRS Hours <u>19</u> Min <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Train Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.M.R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William W. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Florence Ginnimah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>714-05-6836</u>	
17. INFORMANT <u>Alice M. Frank</u>		Address <u>141 W Franklin St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-1</u> , 19 <u>58</u> , to <u>4-6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-5</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		DATE SIGNED <u>4-9-59</u>	
PHYSICIAN'S NAME (Type) <u>Smithsburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24a. REC'D BY REGISTRAR <u>APR 10 '59</u>	
ADDRESS <u>Hagerstown Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hand</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the attending physician. Pages 1 and 2 shall be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 302

VS A15 (4)
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

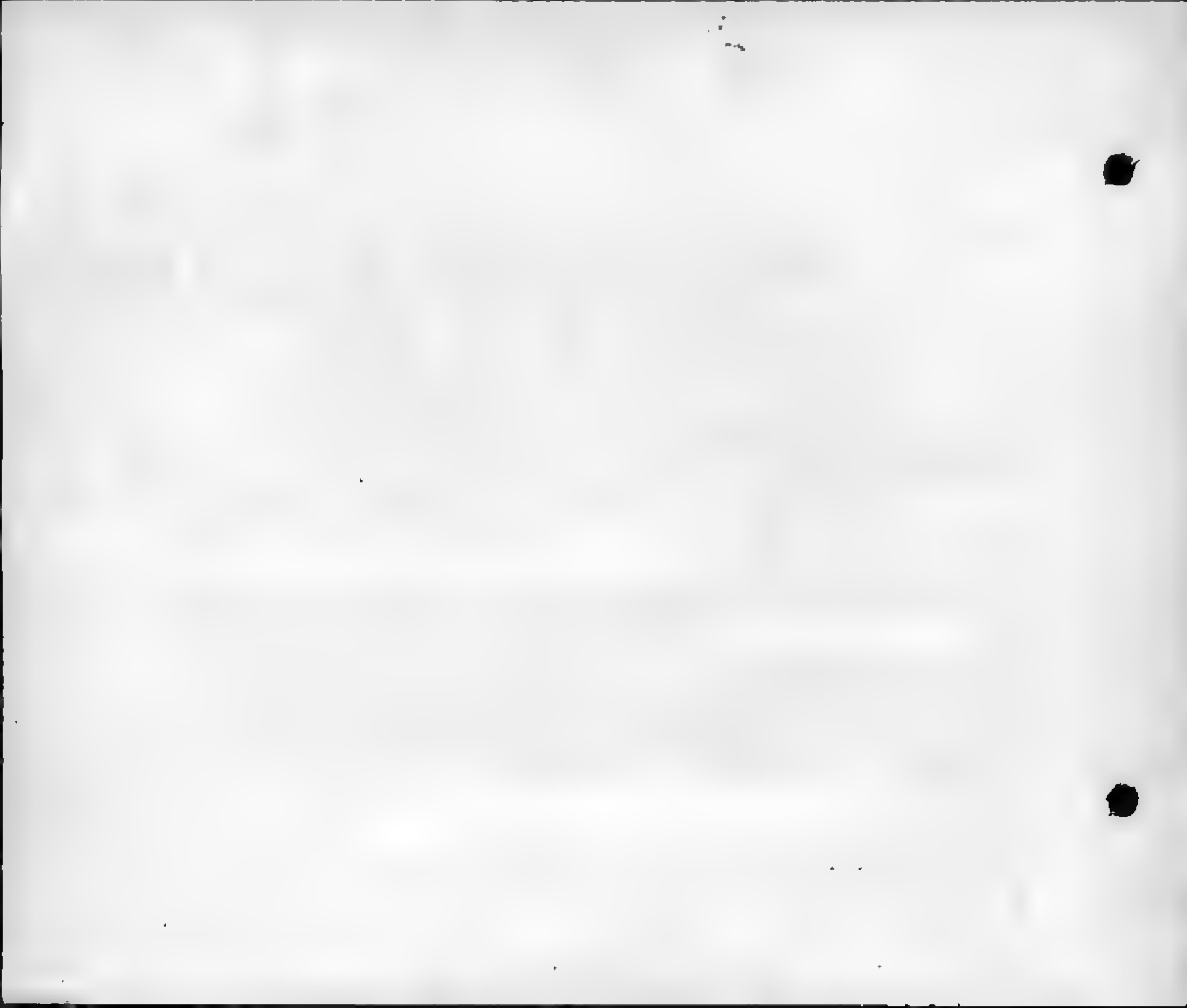
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4837

CERTIFICATE OF DEATH

04830
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 42 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 800 So Potomac St		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 800 So Potomac St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MOSES Middle PHILIP Last GARONZIK		4. DATE OF DEATH Month April Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan'y 20 1873
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		11b. KIND OF BUSINESS OR INDUSTRY Grocery store	
11c. BIRTHPLACE (State or foreign country) Riga Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan Garonzik		14. MOTHER'S MAIDEN NAME Sarah Singer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 217-32-5425	
17. INFORMANT Mrs Ida L. Garonzik		Address 800 So Potomac St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO 42 d. 1 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1956 to April 29, 1959 , that I last saw the deceased alive on April 28, 1959 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R.A.B. ell		ADDRESS (Street, city or town, state) 119 North Potomac Street DATE SIGNED 5-1-59	
PHYSICIAN'S NAME (Type) R.A.B. ell, M.D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/1/59	
22c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House	



4838

CERTIFICATE OF DEATH

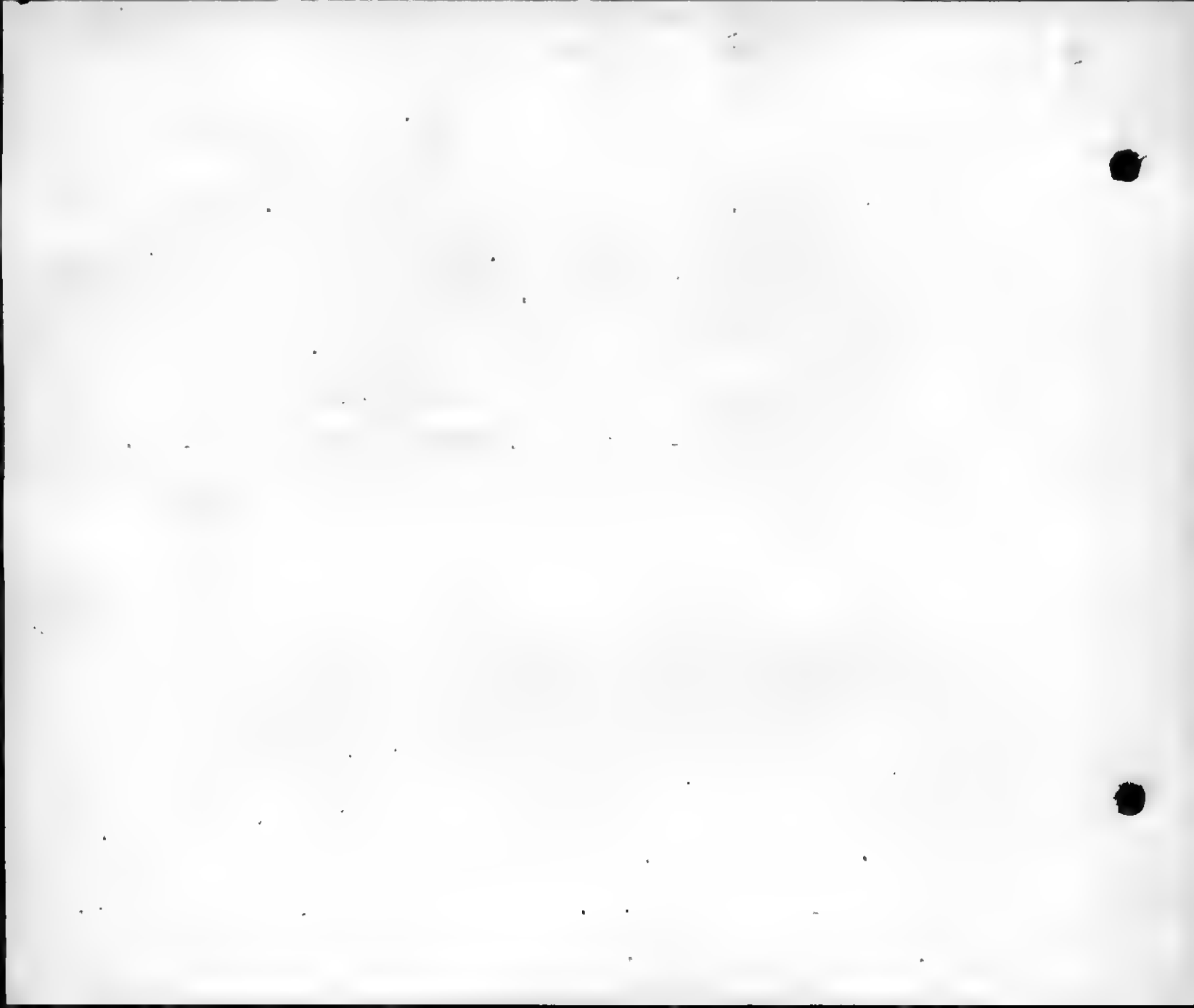
04831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1133 Hamilton Blvd.		d. STREET ADDRESS 1133 Hamilton Blvd.	
3. NAME OF DECEASED (Type or print) First L Middle Keller Last Garver		4. DATE OF DEATH Month 4 Day 29 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1886
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerical		10b. KIND OF BUSINESS OR INDUSTRY Stickells Mill	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Melchor Garver		14. MOTHER'S MAIDEN NAME Emma Harbaugh	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO 220-26-7461	
INFORMANT Mrs. Bertha Garver		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate gland DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 11 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1958 to May 29, 1959 that I last saw the deceased alive on May 29, 1959 , and that death occurred at 6:30 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE Lloyd A. Hoffmann		ADDRESS (Street, city or town, state) 214 N. Potomac st	
PHYSICIAN'S NAME (Type) Lloyd A. Hoffmann		DATE SIGNED 4/30/59	
22a. BURIAL CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 5-1-59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4885

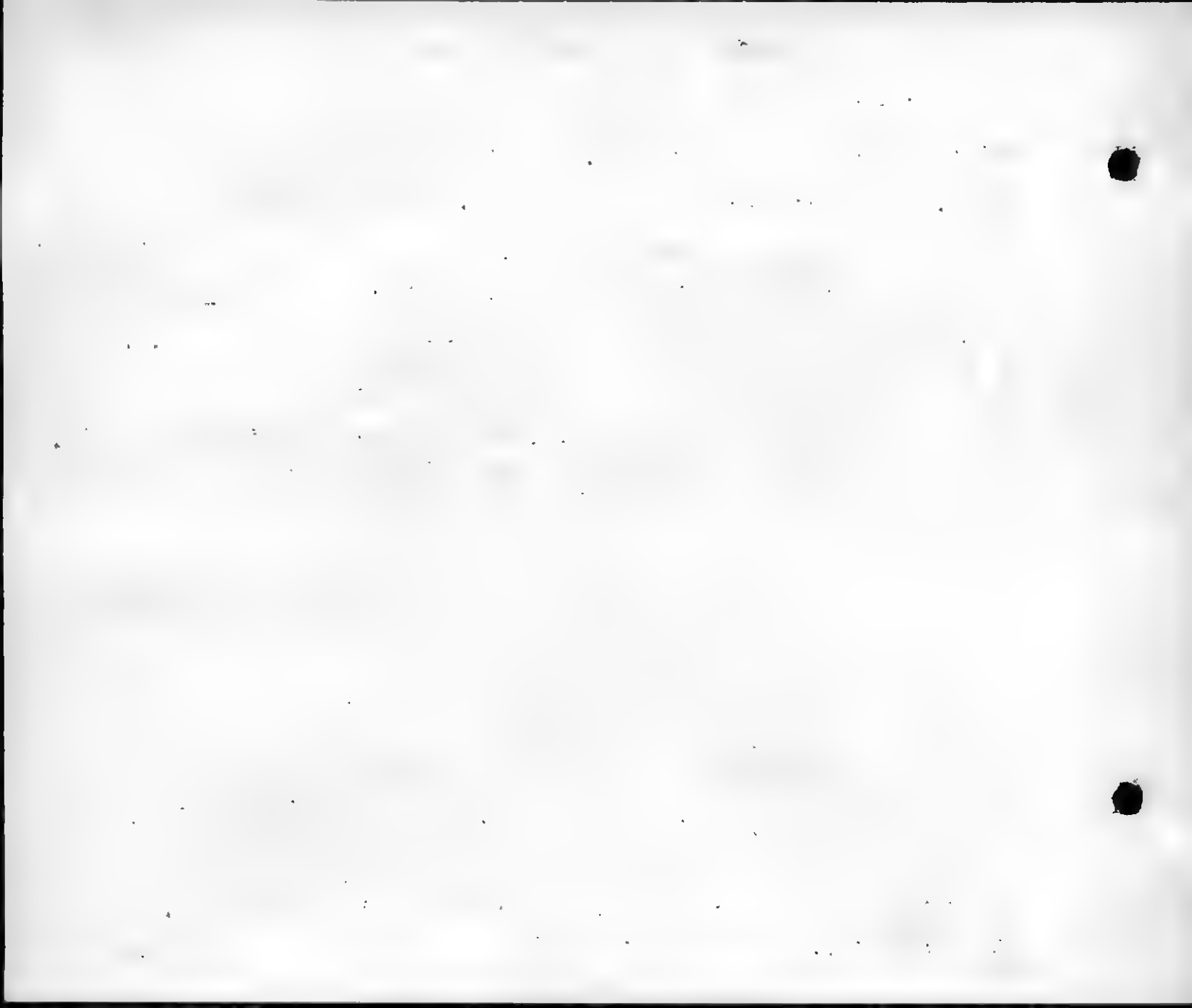
CERTIFICATE OF DEATH

04832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 68 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 W. Salisbury Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rachel Middle Melinda Last Gaylor		4. DATE OF DEATH Month April Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11 1890
9. AGE (in years last birthday) 68		IF UNDER 1 YEAR Months 11 Days 28	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John Harsh	
14. MOTHER'S MAIDEN NAME Jennie Newcomer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		INFORMANT Address Mr. Grayson Newcomer Williamsport Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/7/59 19 to 4/8/59 19 that I last saw the deceased alive on 4/7/59 19, and that death occurred at 11:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE R. F. Young		DATE SIGNED 4/8/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, OR DISPOSITION (Specify) Burial	22b. DATE THEREOF April 11-59	22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	22d. LOCATION (City, town, or county) (State) Williamsport Md.
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leach Williamsport, Md		24a. REC'D BY REGISTRAR DATE APR 13 '59	
ADDRESS Williamsport, Md		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

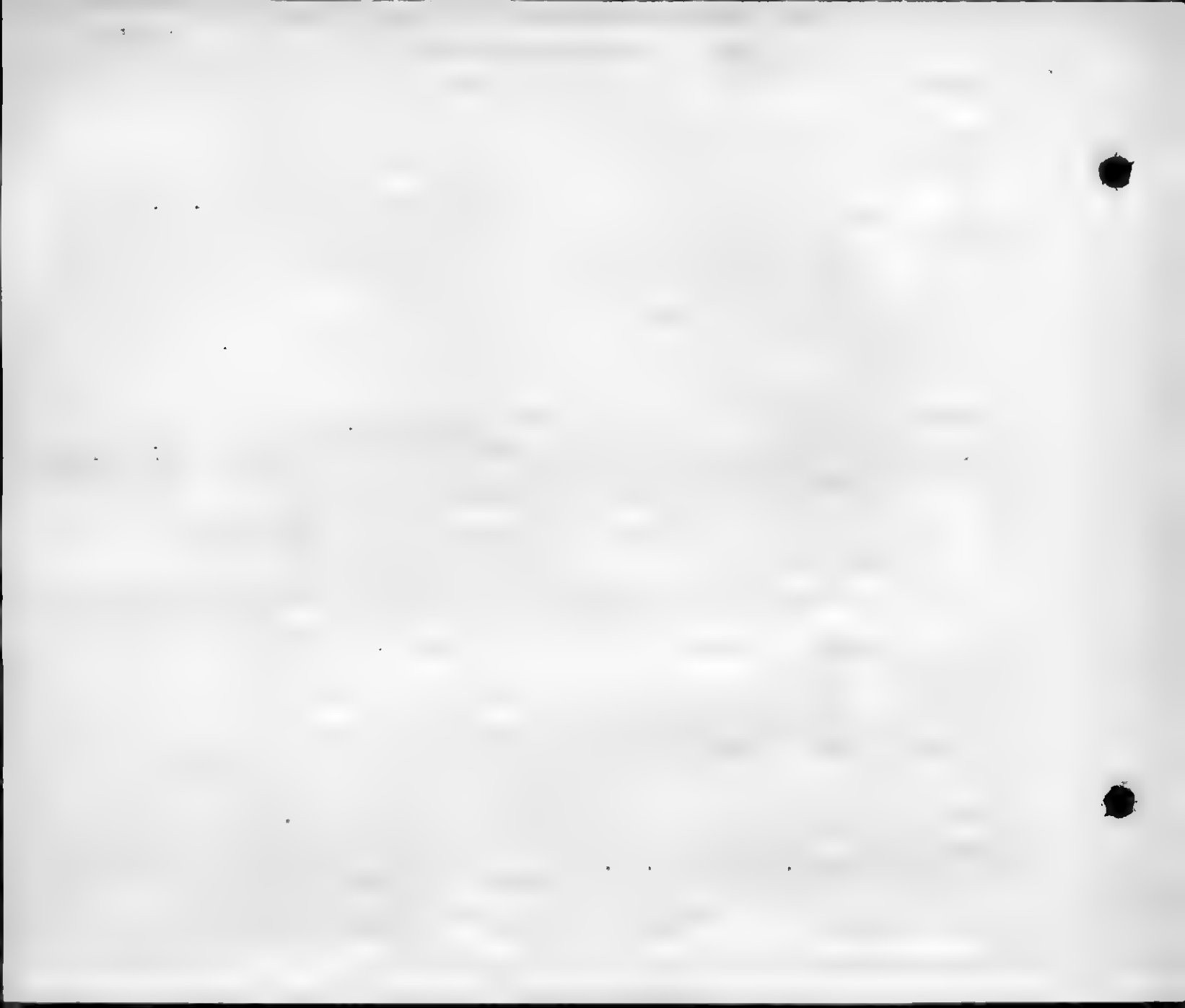
4885

CERTIFICATE OF DEATH

04833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dargan				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				e. STREET ADDRESS RFD#1, Harpers Ferry, W.Va.			
3. NAME OF DECEASED (Type or print) First SARAH Middle VIRGINIA Last GIFFIN				4. DATE OF DEATH Month April Day 28 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1885	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 3 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington County, Md.	
13. FATHER'S NAME Franklin Huff				14. MOTHER'S MAIDEN NAME Ellen Pierce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Samuel E. Giffin Address RFD #1, Harpers Ferry, West Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4/27/59 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardio-vascular disease 5 Yrs DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. n. Month, 19 Day, 19 Year p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sharpburg, Md.	
21. I certify that I attended the deceased from 4/27/59 , 19____, to 4/28/59 , 19____, that I last saw the deceased alive on 4/27/59 , 19____, and that death occurred at 10:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpburg, Md. DATE SIGNED April 30, 1959 ACTUAL SIGNATURE Walter H. Shealy M.D. NAME (Type) Walter H. Shealy M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/59		22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		22d. LOCATION (City, town, or county) (State) Samples Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Donald C. Coker				24a. REC'D BY REGISTRAR DATE MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4839

CERTIFICATE OF DEATH

04834

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN TB 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 242 S. Potomac Street	
3. NAME OF DECEASED (Type or print) First THELMA Middle MILLER Last GILLECE		4. DATE OF DEATH Month April Day 30 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1902
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Funkstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dallas Miller		14. MOTHER'S MAIDEN NAME Steele R. Little	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Margaret V. Reardon		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hepatic coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Portal Cirrhosis DUE TO (c) Chronic alcoholism			INTERVAL BETWEEN ONSET AND DEATH 4 days 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-29 , 19 59 , to 4-30 , 19 59 , that I last saw the deceased alive on 4-30 , 19 59 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John D. Tuxie		ADDRESS (Street, city or town, state) JOHN D. TUXIE	
PHYSICIAN'S NAME (Type) John D. Tuxie		DATE SIGNED 4-30-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/1959	22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	22d. LOCATION (City, town, or county) (State) Hancock, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR MAY 6 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

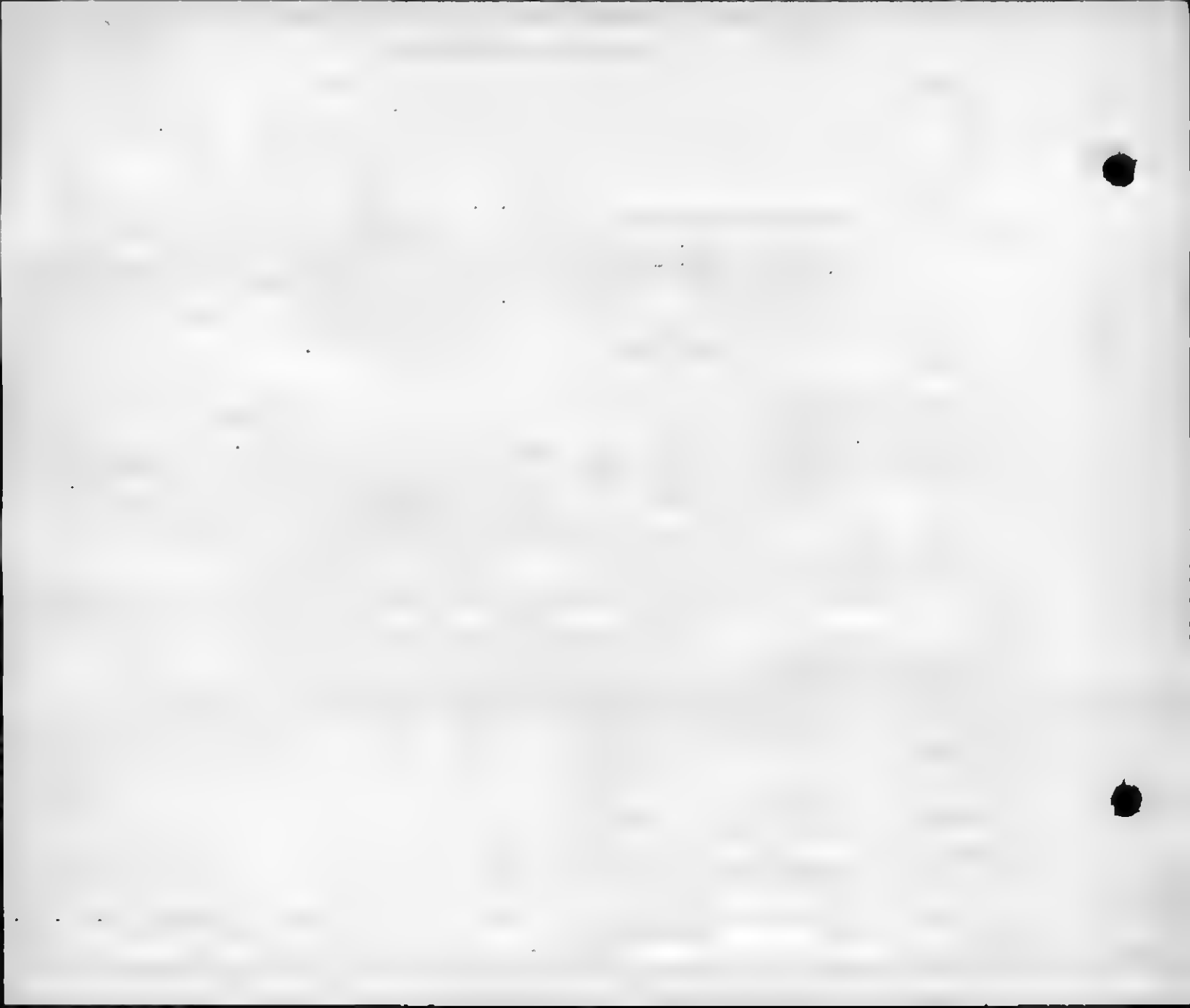
4887

CERTIFICATE OF DEATH

04835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook		c. LENGTH OF STAY IN 1b 60 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		/d. STREET ADDRESS U.S. Route # 340	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IDA Middle SOPHIA Last HARRISON		4. DATE OF DEATH Month April Day 21 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1878
9. AGE (In years last birthday) 80 yrs		10. BIRTHPLACE (State or foreign country) Yarrowsburg, Md.	11. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
13. FATHER'S NAME John David Fouch		14. MOTHER'S MAIDEN NAME Sarah Elizabeth West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Junie Harrison		18. ADDRESS RFD # 1, Knoxville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 int. 9 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1952 , to 4/21 , 19 59 , that I last saw the deceased alive on 4/20 , 19 59 , and that death occurred at 11:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L. B. Cooper		ADDRESS (Street, city or town, state) DATE SIGNED Brunswick, Md. 4/24/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/59	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Bolivar, Jefferson Co., W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Donald Eckles		24a. REC'D BY REGISTRAR APR 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. H. [unclear]			



4888

CERTIFICATE OF DEATH

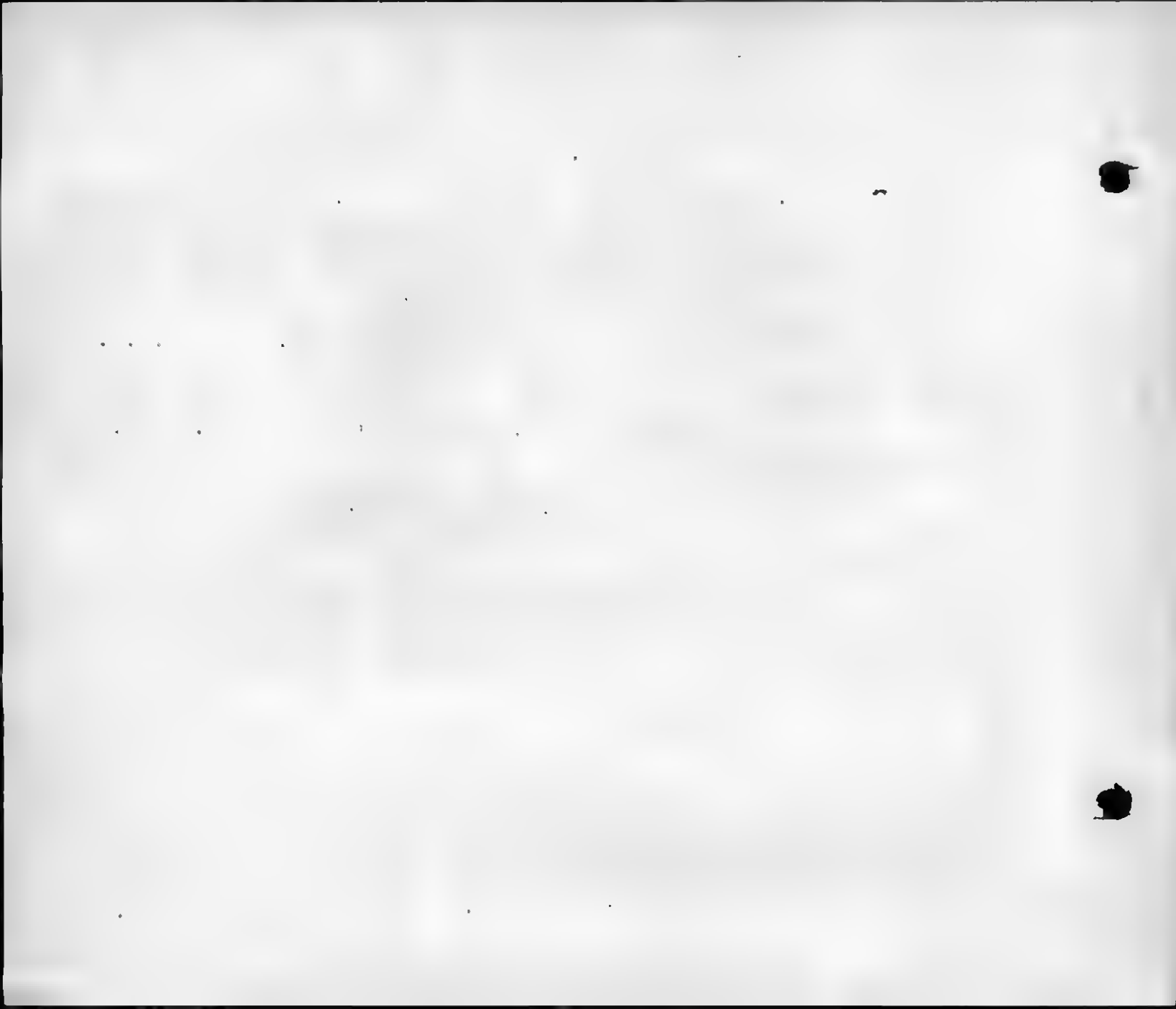
04836

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b 36 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WHITE HALL RT.#1 HAGERSTOWN		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL HAGERSTOWN	
f. STREET ADDRESS WHITE HALL RT.#1 HAGERSTOWN		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VALLIE Middle ARMENIA Last HARSHMAN		4. DATE OF DEATH Month APRIL Day 18 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 14 Hours 19 Min 59	11. IF UNDER 24 HRS. Months 8 Days 14 Hours 19 Min 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) BOONSBORO MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY LEE HOOVER		14. MOTHER'S MAIDEN NAME SARAH EASTERDAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MR. EMERSON HARSHMAN		Address HAGERSTOWN RT.#3 MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart D. DUE TO Belated Thrombo-Phlebitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Belated Thrombo-Phlebitis (c) Belated Thrombo-Phlebitis			INTERVAL BETWEEN ONSET AND DEATH 8 yrs. April 6 - 1959
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 11, 1952 to April 18, 1959 that I last saw the deceased alive on April 18, 1959 and that death occurred at 7:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) HAGERSTOWN MD. DATE SIGNED 4-20-59			
ACTUAL SIGNATURE SIDNEY NOVENSTEIN M.D. SIDNEY NOVENSTEIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/21/59	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.
22d. LOCATION (City, town, or county) HAGERSTOWN		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 22 1959	24b. REGISTRAR'S SIGNATURE C. L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

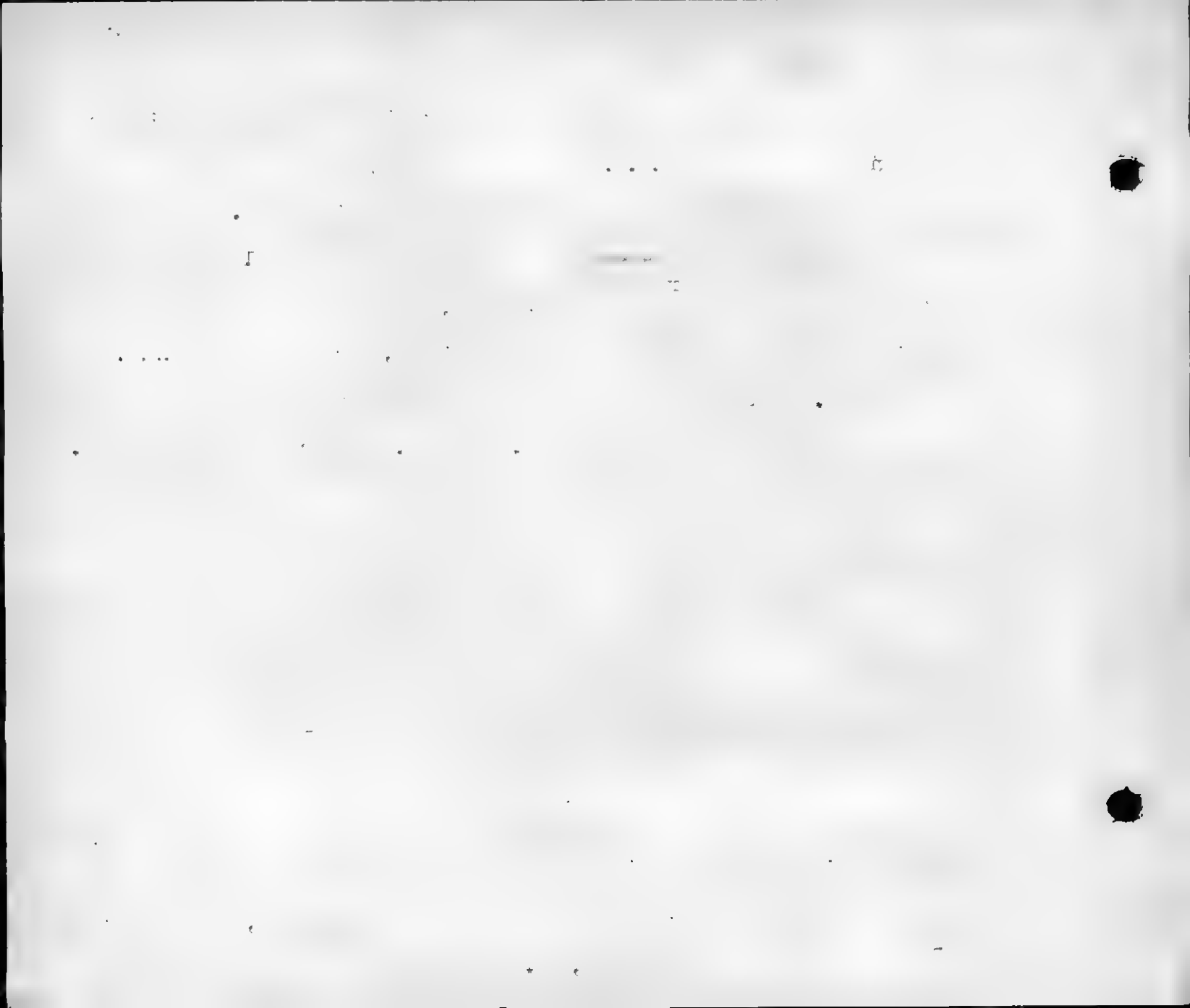
04837

Reg. Dist. No. 302

4840

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 128 East Washington St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) FLORENCE GRAMMS HAWTHORNE	4. DATE OF DEATH Month April Day 21 Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1894
9. AGE (In years last birthday) 64 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George W. Watts		14. MOTHER'S MAIDEN NAME Ann Gramms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Mr. Lawson P. Hawthorne		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) - - -
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		24a. REC'D BY REGISTRAR APR 27 59	
24b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

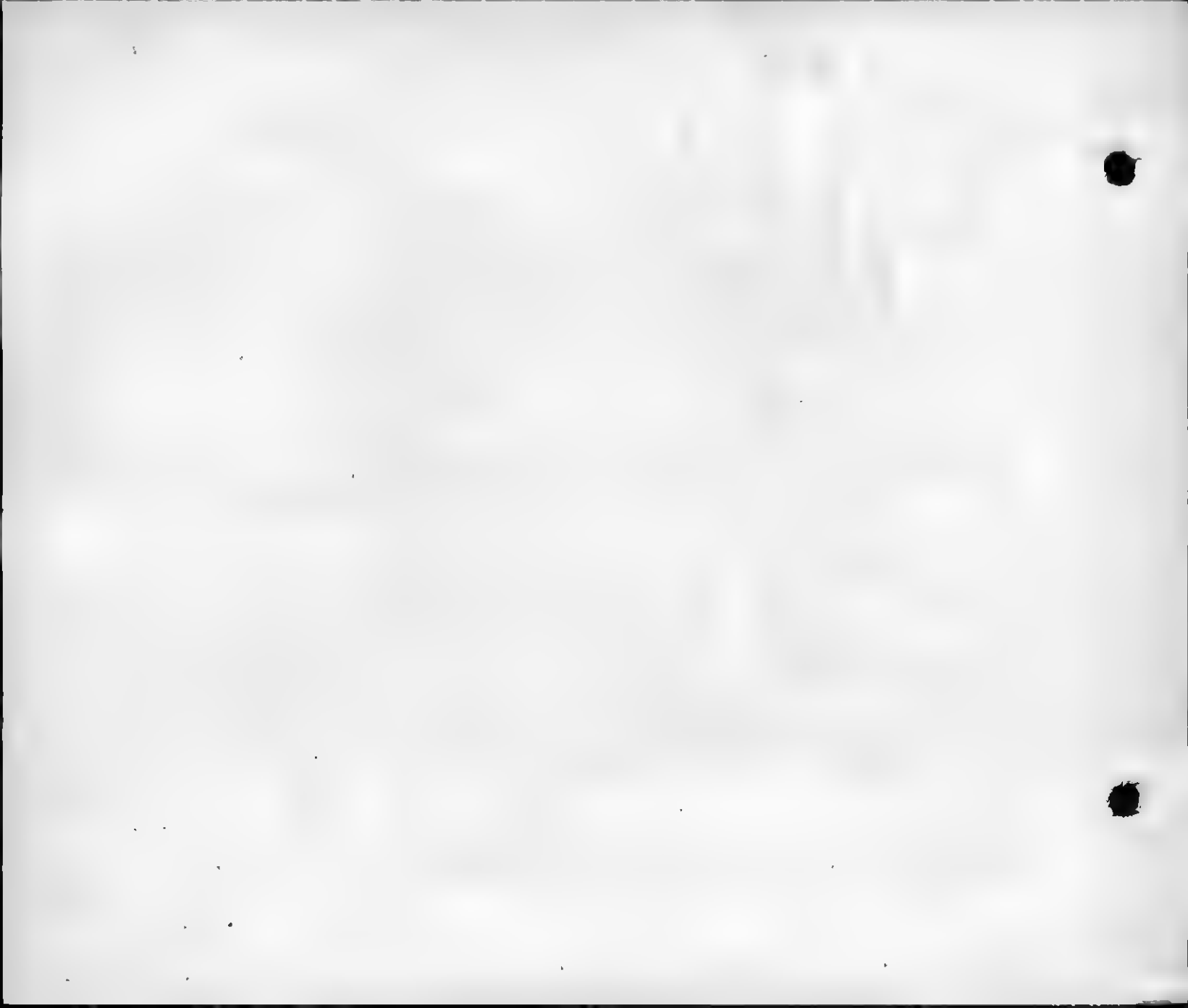
04838
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 40 Yrs		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 416 Guilford Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MOLLY CATHERINE HECK		4. DATE OF DEATH Month Day Year April 28 1959 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH sept 27 1871
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) Id		12. CITIZEN OF WHAT COUNTRY? Co USA	
13. FATHER'S NAME Samuel Henry Boyer		14. MOTHER'S MAIDEN NAME Minerva Ann McCoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Francis Heck 111 King St		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 2, 1957 to Apr. 28, 1959 that I last saw the deceased alive on April 21, 1959 and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. A. Bell		ADDRESS (Street, city or town, state) DATE SIGNED 119 North Potomac St. Apr. 29, 1959	
PHYSICIAN'S NAME (Type) R. A. Bell.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/1/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR DATE MAY 4 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04840

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN lb 50 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 7 Moller Ave.	e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle KENNETH Last HOUP		4. DATE OF DEATH Month April Day 6 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1893
9. AGE (in years last birthday) 65 yrs		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Dust Collecting	
11. BIRTHPLACE (State or foreign country) Boonesboro, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph H. Houpt		14. MOTHER'S MAIDEN NAME Annie G. Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) July 1916		16. SOCIAL SECURITY NO. 214-09-5792	
17. INFORMANT Mrs. Harry K. Houpt		Address 7 Moller Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis 4 DUE TO Arteriosclerotic coronary heart disease Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour 11:00 AM none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) Burial 4/8/59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4890

Item 9 File 6241 4-27-59 et

CERTIFICATE OF DEATH

04841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Ringgold c. LENGTH OF STAY IN 1b 56 Years		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Ringgold d. STREET ADDRESS Smithsburg #2 • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nora Middle E. Last Huff		4. DATE OF DEATH Month April Day 19 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/1883 9. AGE (In years last birthday) 75 1/6 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Smithsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Noford		14. MOTHER'S MAIDEN NAME Clarine Brightwiser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Walter L. Huff, Smithsburg Md., #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) 5 yrs. INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-19-59 , 19 59 , to 4-19-59 , 19 59 , that I last saw the deceased alive on 4-19-59 , 19 59 , and that death occurred at 2:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 4-1-59			
ACTUAL SIGNATURE Charles E. Hogg M.D.		PHYSICIAN'S NAME (Type) Charles E. Hogg, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/22/59	22c. NAME OF CEMETERY OR CREMATORY Ringgold	22d. LOCATION (City, town, or county) (State) Smithsburg #2, Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE Walter L. Huff		24a. REC'D BY REGISTRAR APR 22 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hogg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4843

CERTIFICATE OF DEATH

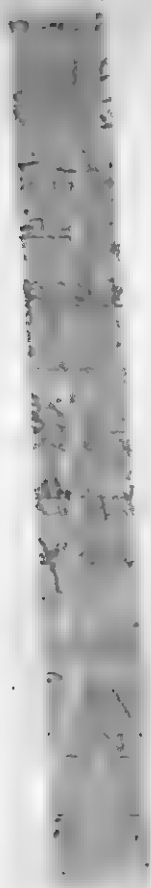
04842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>6 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY - LEO - JONES</u>				4. DATE OF DEATH Month Day Year <u>APRIL 3 1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 6. 1881</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER -</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM WORK</u>			
11. BIRTHPLACE (State or foreign country) <u>KEEDYSVILLE WASH. CO. MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN H. JONES</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. MCNAMEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-30-5897A</u>			
17. INFORMANT <u>LLOYD BITNER</u>				Address <u>BOONSBORO MD. R. 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLUENT LOBULAR PNEUMONIA - BILATERAL</u> 134X DUE TO 9 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF RECTUM WITH GENERALIZED METASTASIS</u> 4 YEARS (c) <u>METASTASIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BILATERAL HYDRONEPHROSIS</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>NOV. 24</u> , 19 <u>58</u> , to <u>APRIL 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>APRIL 3</u> , 19 <u>59</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED <u>1500 PRUNGSLOVANIA AVE</u> <u>4-3-59</u>							
ACTUAL SIGNATURE <u>Ernesto R. Laddizabal</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Ernesto R. Laddizabal Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>APRIL 5, 59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>W. TILGHMAN TOWN WASH. CO. MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John W. Bad Boonsboro Md</u>							
24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. A. F. F. F.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

04843

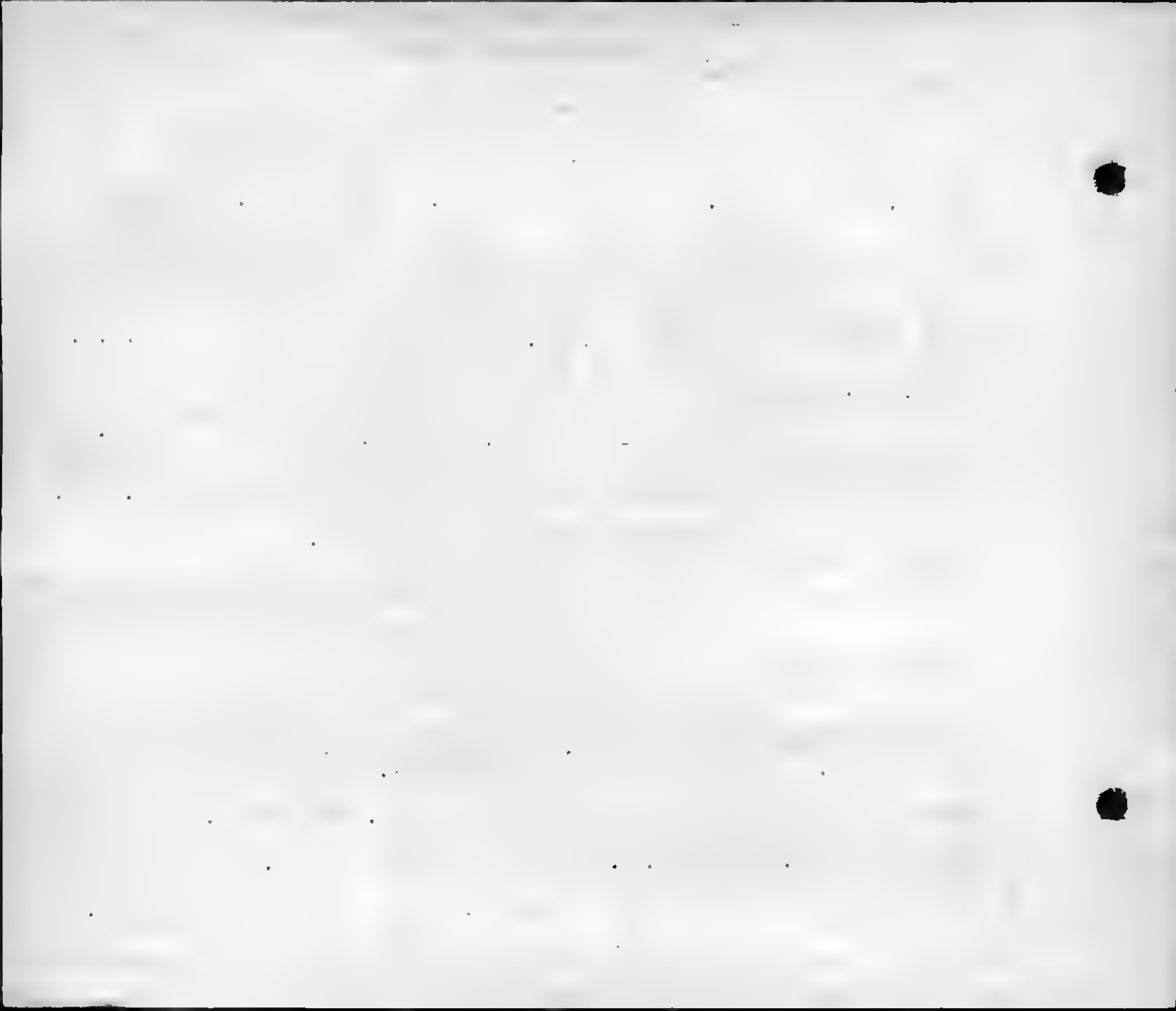
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 253 S. MULBERRY ST.		d. STREET ADDRESS 253 S. MULBERRY ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MILDRED Middle ORPHA Last JORDAN		4. DATE OF DEATH Month APRIL Day 21 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/15/1912
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE DRESSER		10b. KIND OF BUSINESS OR INDUSTRY SHOE MFG. CO.	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FLOYD W. GRIFFITH		14. MOTHER'S MAIDEN NAME FLORA MAE LEWIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 220-16-0123	
17. INFORMANT MR. FLOYD W. GRIFFITH		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY INVOLVEMENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CANCER WITH GENERALIZED METASTASIS. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1958			INTERVAL BETWEEN ONSET AND DEATH APP. 6 MO.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4 DEC. 19 58 , to 18 APR. 19 59 , that I last saw the deceased alive on 18 APR. 19 59 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 251 E. Baltimore St. DATE SIGNED ACTING SIGNATURE Hugo A. Sacchet M.D. PHYSICIAN'S NAME (Type) Hugo A. Sacchet, M. D. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/24/59	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR APR 24 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4845

CERTIFICATE OF DEATH

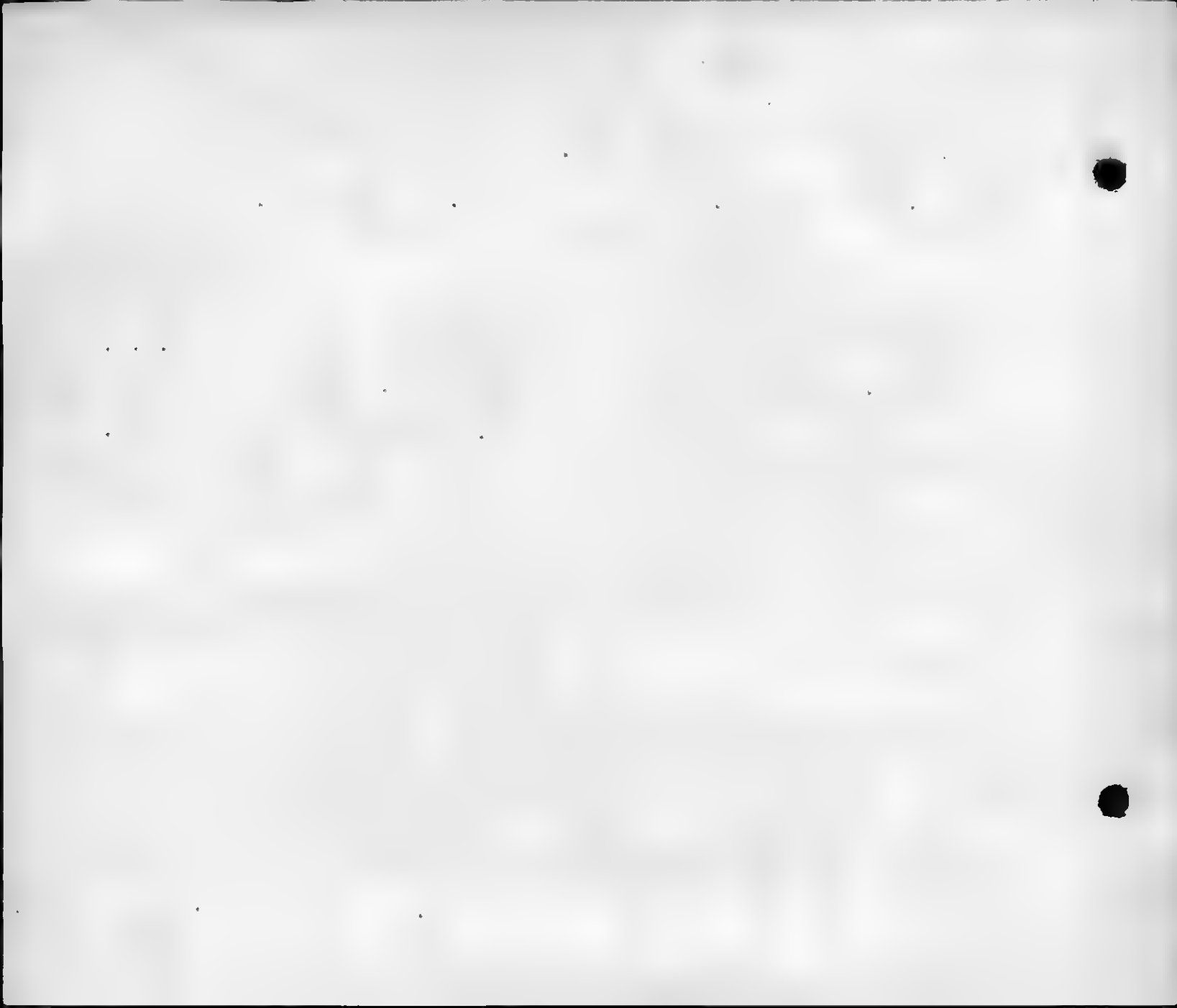
04844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 45 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 E. BALTIMORE ST.		d. STREET ADDRESS 21 E. BALTIMORE ST.	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle DEE Last JUDD		4. DATE OF DEATH Month APRIL Day 3 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY CITY LIGHT PLANT VIRGINIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN S. JUDD		14. MOTHER'S MAIDEN NAME MOLLIE A. JUDD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 214-09-7758	
17. INFORMANT MRS. MARYETTA McCORMICK Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerotic heart disease DUE TO (c) 2 years			INTERVAL BETWEEN ONSET AND DEATH 3 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Jan , 19 52 , to 3 April , 19 59 , that I last saw the deceased alive on 1 April , 19 59 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldon G. Hoachlander		ADDRESS (Street, city or town, state) 115 W. Wash. St. Hagerstown Md.	
PHYSICIAN'S NAME (Type) Eldon G. Hoachlander		DATE SIGNED April 4 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/5/59	22c. NAME OF CEMETERY OR CREMATORY BEAUMS CHAPEL CEM.	22d. LOCATION (City, town, or county) (State) LURAY VA.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Korman ADDRESS Hagerstown Md.		24a. REC'D. BY REGISTRAR APR 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

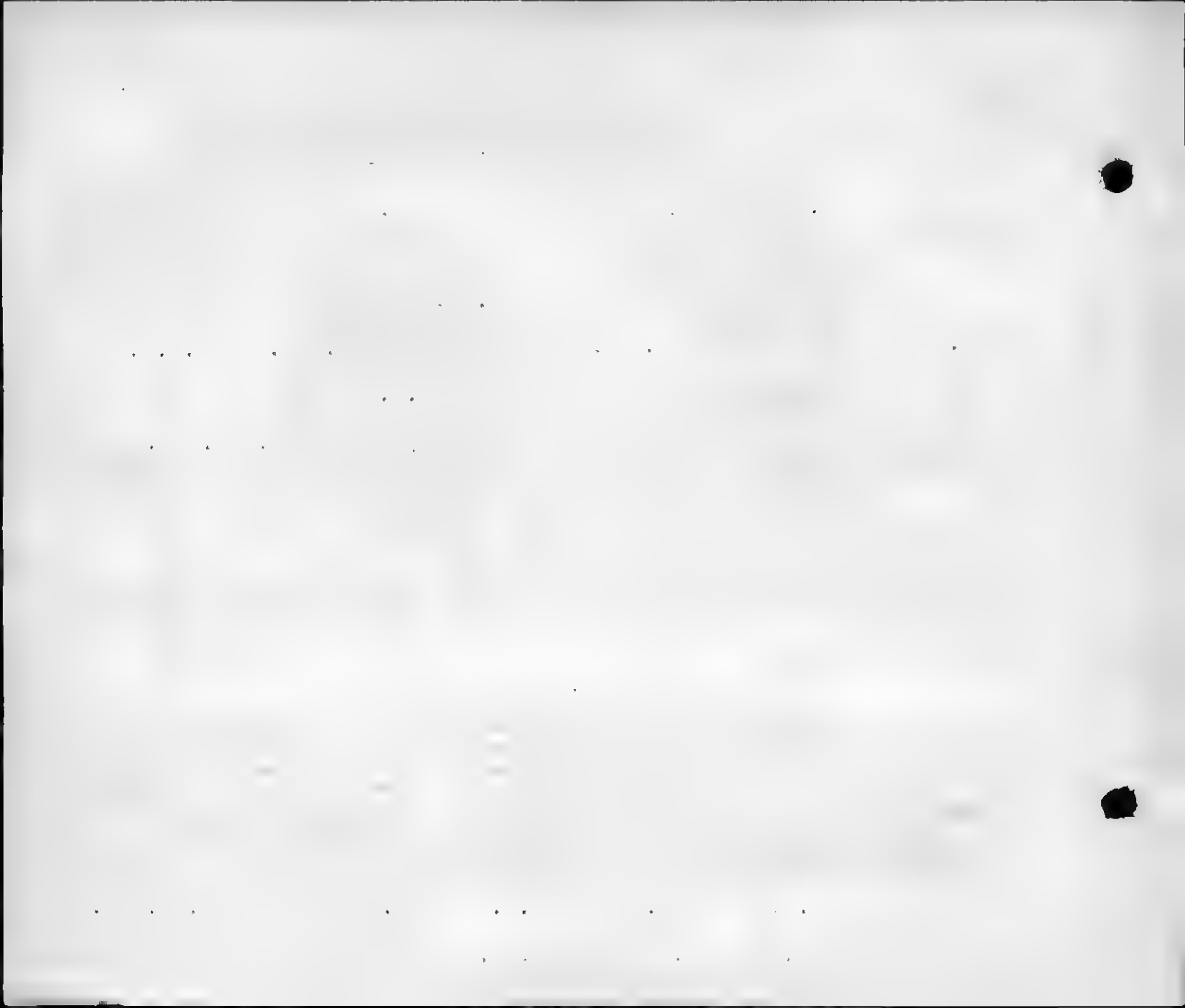
4846

CERTIFICATE OF DEATH

Reg. Dist. No. 04845

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg- Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS Route # 1.			
3. NAME OF DECEASED (Type or print) First EMORY Middle KELBAUGH Last KELBAUGH				4. DATE OF DEATH Month April Day 1 Year 1959			
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1870	9. AGE (In years last birthday) 88 yrs	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Gen. Farm		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kelbaugh				14. MOTHER'S MAIDEN NAME Mary S.E. Forrest			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James Smith, Smithsburg, Md. Rt. #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Toxicemia 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Kidney function failure DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Mar. 20 , 19 59 , to Mar. 30 , 19 59 , that I last saw the deceased alive on Mar. 30 , 19 59 , and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont - Md DATE SIGNED ACTUAL SIGNATURE James K. Gray M.D. Thurmont - Md PHYSICIAN'S NAME (Type) James K. Gray							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 4, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Bethel M.E.	22d. LOCATION (City, town, or county) Nr. Garfield Fred. Co. Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle ADDRESS Paul F. Bittle, Myersville, Md.		24a. REC'D BY REGISTRAR DATE APR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Klaus				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4891

CERTIFICATE OF DEATH

Reg. Dist. No. 04846

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u>				c. LENGTH OF STAY IN 1b <u>25 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R.2</u>				d. STREET ADDRESS <u>BOONSBORO MD. R.2</u>			
3. NAME OF DECEASED (Type or print) <u>FOSTER B</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-23-1894</u>		9. AGE (In years last birthday) <u>64</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICAL CONTRACTOR - RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FRED. CO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARLETON E. KEPHART</u>				14. MOTHER'S MAIDEN NAME <u>WARREN FELTZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>218-30-9872</u>		17. INFORMANT <u>CECIL F. KEPHART BOONSBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.7</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart D</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>April 7-14 59.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 7</u> , 19 <u>59</u> , to <u>April 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April</u> , 19 <u>59</u> , and that death occurred at <u>1:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4-11-59</u>							
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.				PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL-13-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>				ADDRESS <u>BOONSBORO MD</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

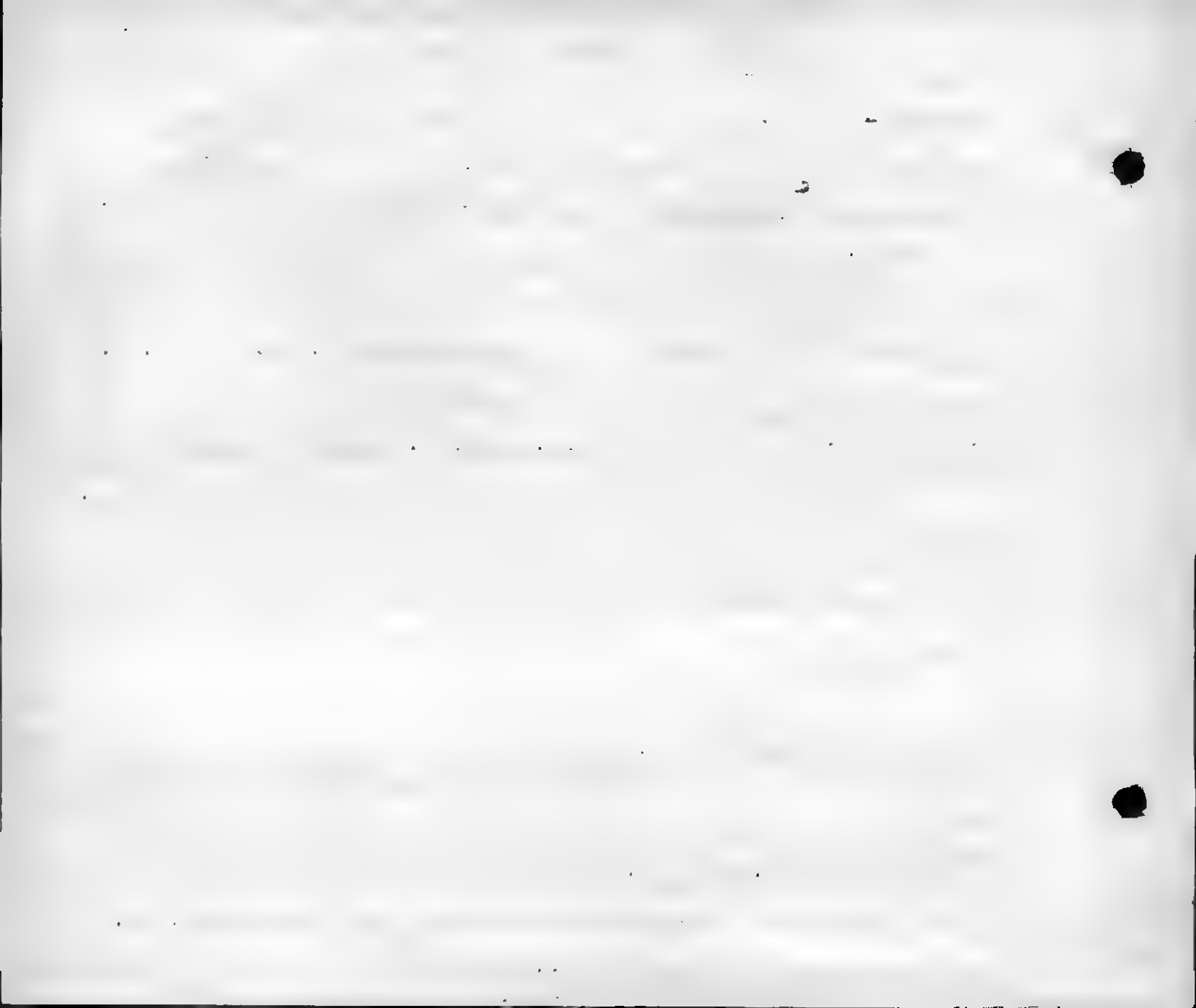
4847

CERTIFICATE OF DEATH

Reg. Dist. No. 01847

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 18 hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS Hagerstown Route #4		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roscoe		First Paul Middle Keplinger Last		4. DATE OF DEATH April		Month 2 Day 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1901		9. AGE (In years last birthday) 57 yrs	IF UNDER 1 YEAR Months 11 Days 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoe laster		10b. KIND OF BUSINESS OR INDUSTRY shoe		11. BIRTHPLACE (State or foreign country) nr. Bakersville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Keplinger				14. MOTHER'S MAIDEN NAME Anna Mull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs. Ethel G. Keplinger		Address Route #4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1-59 , 19____, to 4-2-59 , 19____, that I last saw the deceased alive on 4-1-59 , 19____, and that death occurred at 7:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 4-2-59							
ACTUAL SIGNATURE Charles E. Hoss		M.D. Baltimore, Md.					
PHYSICIAN'S NAME (Type) Charles E. Hoss, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-4-59		22c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		22d. LOCATION (City, town, or county) (State) near Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Minnich				ADDRESS 415 Wilson Blvd., East		24a. REC'D BY REGISTRAR DATE APR 6 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hoss	

Minnich Funeral Home, Hagerstown, Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04848

4892

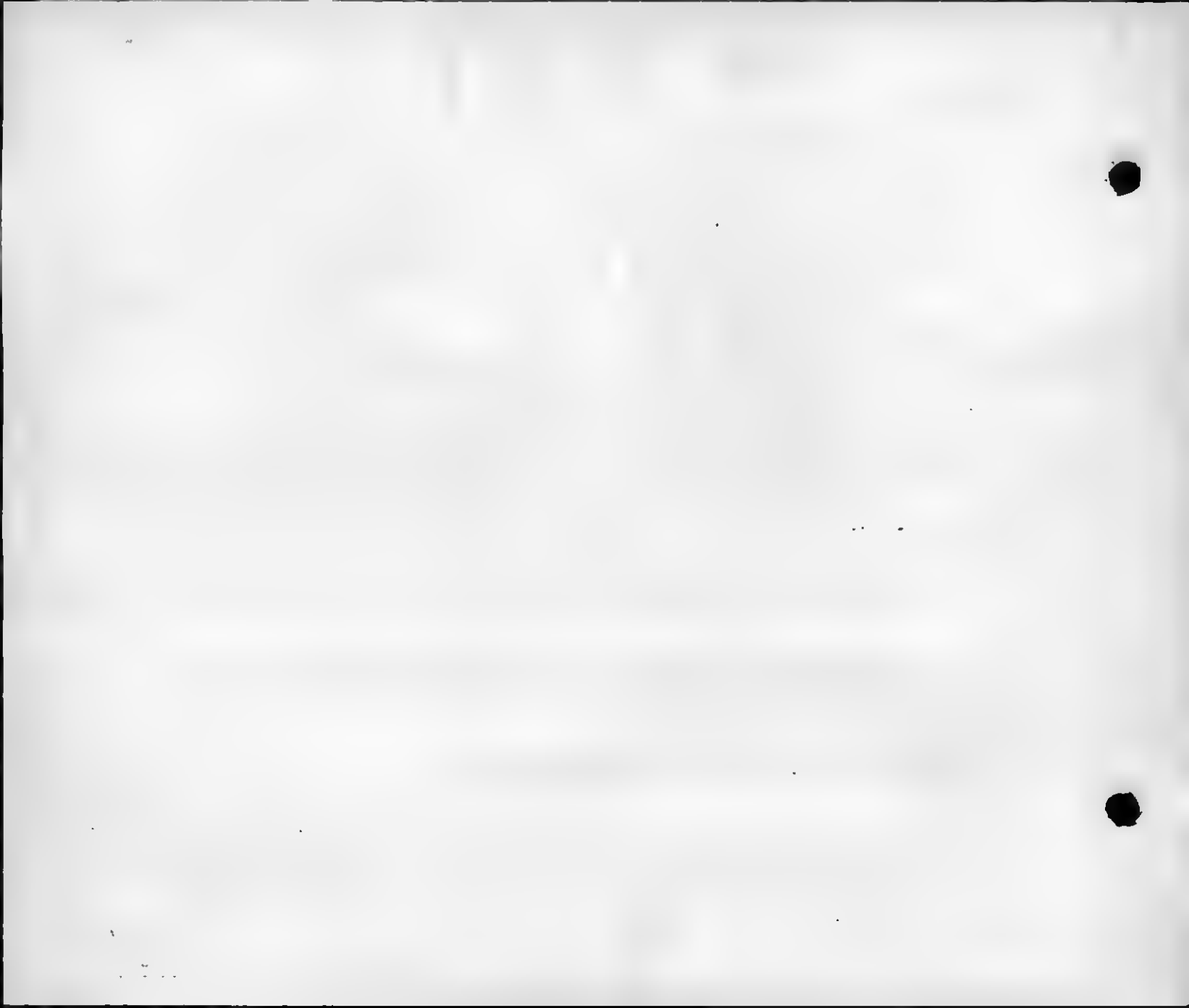
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR</u> c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BOONSBORO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAHRNEY-KEEDY MEMORIAL HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE - DAISY - KLINE</u>		4. DATE OF DEATH Month <u>APRIL</u> - Day <u>7</u> - Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 14. 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	11. IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>FRED. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANKLIN E. ALEXANDER</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA E. SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>MRS. MARGARET STERNER</u>		Address <u>BOONSBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>2 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1</u> 19 <u>59</u> to <u>April 7</u> 19 <u>59</u> , that I last saw the deceased alive on <u>April 7</u> 19 <u>59</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>4/9/59</u> ACTUAL SIGNATURE <u>G. W. L. L. L.</u> M.D. <u>G. W. L. L. L.</u> PHYSICIAN'S NAME (Type) <u>G. W. L. L. L.</u> <u>Ind.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APR 10. 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Bash</u>		ADDRESS <u>Boonsboro Md</u>	24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G242 5-6-59 et

4893

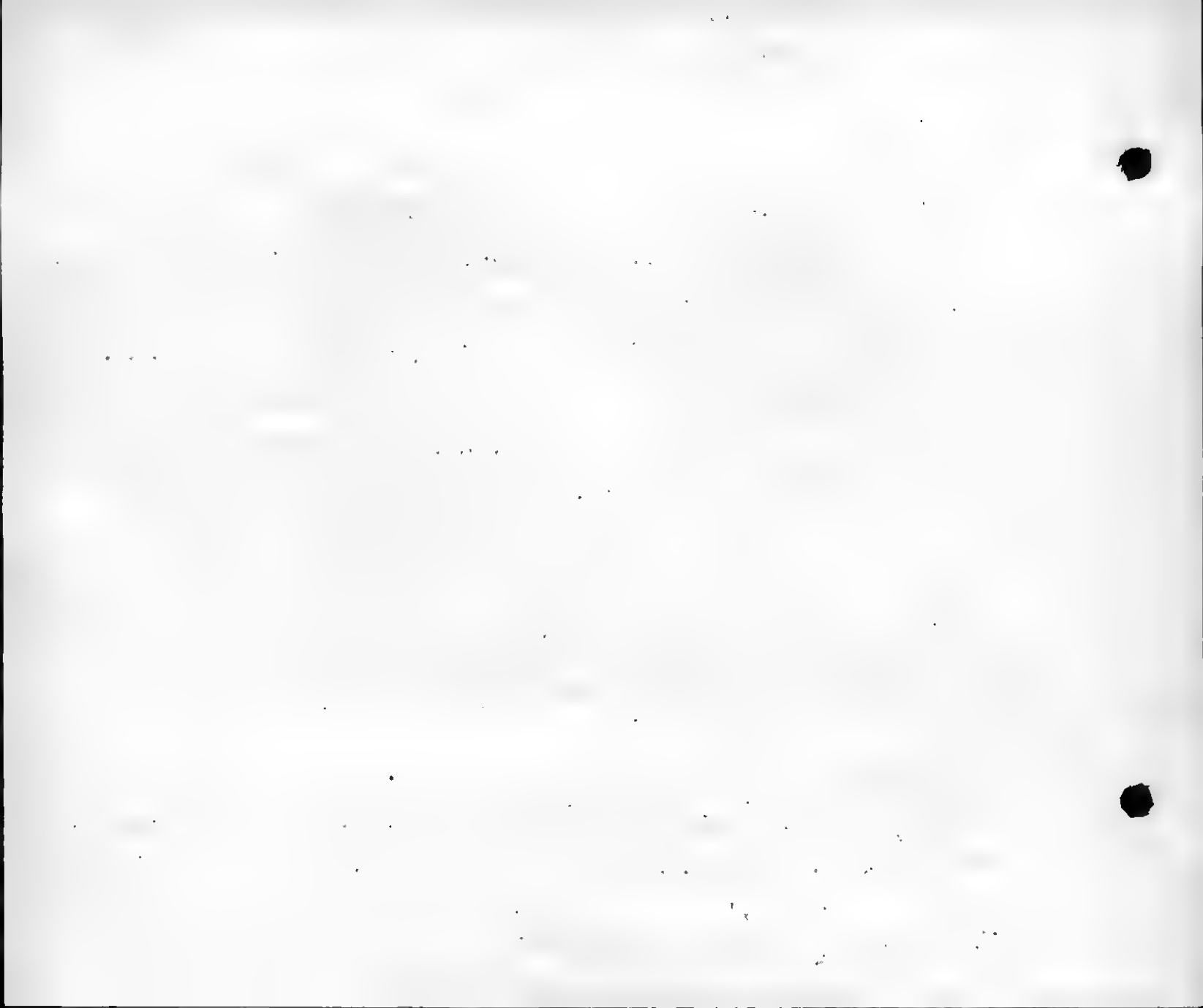
CERTIFICATE OF DEATH

04849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>7</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLIAMSPORT</u>		c. LENGTH OF STAY IN 1b <u>3 yrs 11 mos 5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>102 LYNN CORE DRIVE</u>							
3. NAME OF DECEASED (Type or print) <u>WILLIAM S. KLINE</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>NOV 10, 1878</u>			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>		11. BIRTHPLACE (State or foreign country) <u>Mc Keesport, Pa</u>			
13. FATHER'S NAME <u>DANIEL KLINE</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>CATHERINE ENGLEBRICHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				14. MOTHER'S MAIDEN NAME <u>MRS. J.C. TERRY (DAUGHTER)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congrenous to - Paralytic ileus</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
19		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <u>AUG 1</u> , 19 <u>59</u> , to <u>April 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>59</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Williamsport, Md</u> DATE SIGNED <u>April 28, 1959</u>							
ACTUAL SIGNATURE <u>Max E. Byrkit</u>		PHYSICIAN'S NAME (Type) <u>Max E. Byrkit, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 27, '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Martinsburg Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert S. Leaf Williamsport, Md</u>					
24a. REC'D BY REGISTRAR DATE <u>APR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4848

CERTIFICATE OF DEATH

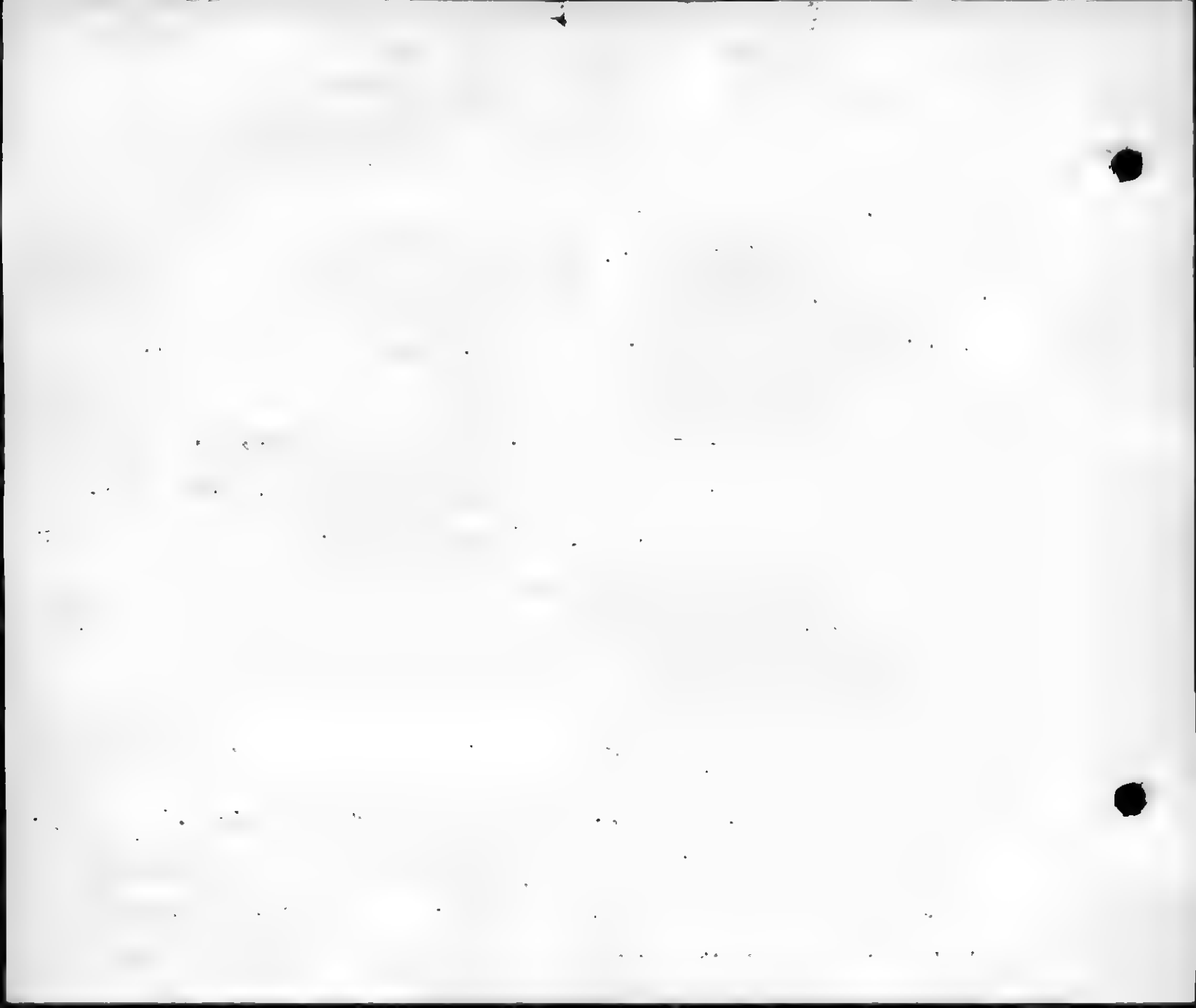
04850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Unk d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville d. STREET ADDRESS 128 - 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Charles Last Kolb		4. DATE OF DEATH Month April Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Nov 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min. 85	11. IF UNDER 24 HRS Months 85 Days 85 Hours 85 Min. 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Butcher	11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Christian Kolb	
14. MOTHER'S MAIDEN NAME Caroline Whitman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 216-01-7182		INFORMANT Address Mrs. Caroline Suek, Cullen, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1950 CONFLUENT lobular pneumonia, bilateral DUE TO (b) carcinoma of adrenals & metastasis DUE TO (c) to ribs, vertebrae and liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	
20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20d. (City or town) (County) (State)		20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4 , 1959, to April 17 , 1959, that I last saw the deceased alive on April 17 , 1959, and that death occurred at 1:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Victor L. Ramos M.D.		ADDRESS (Street, city or town, state) Western Md. State Hospital DATE SIGNED April 17/59	
PHYSICIAN'S NAME (Type) Victor L. Ramos		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-20-59	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 20 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

091

1



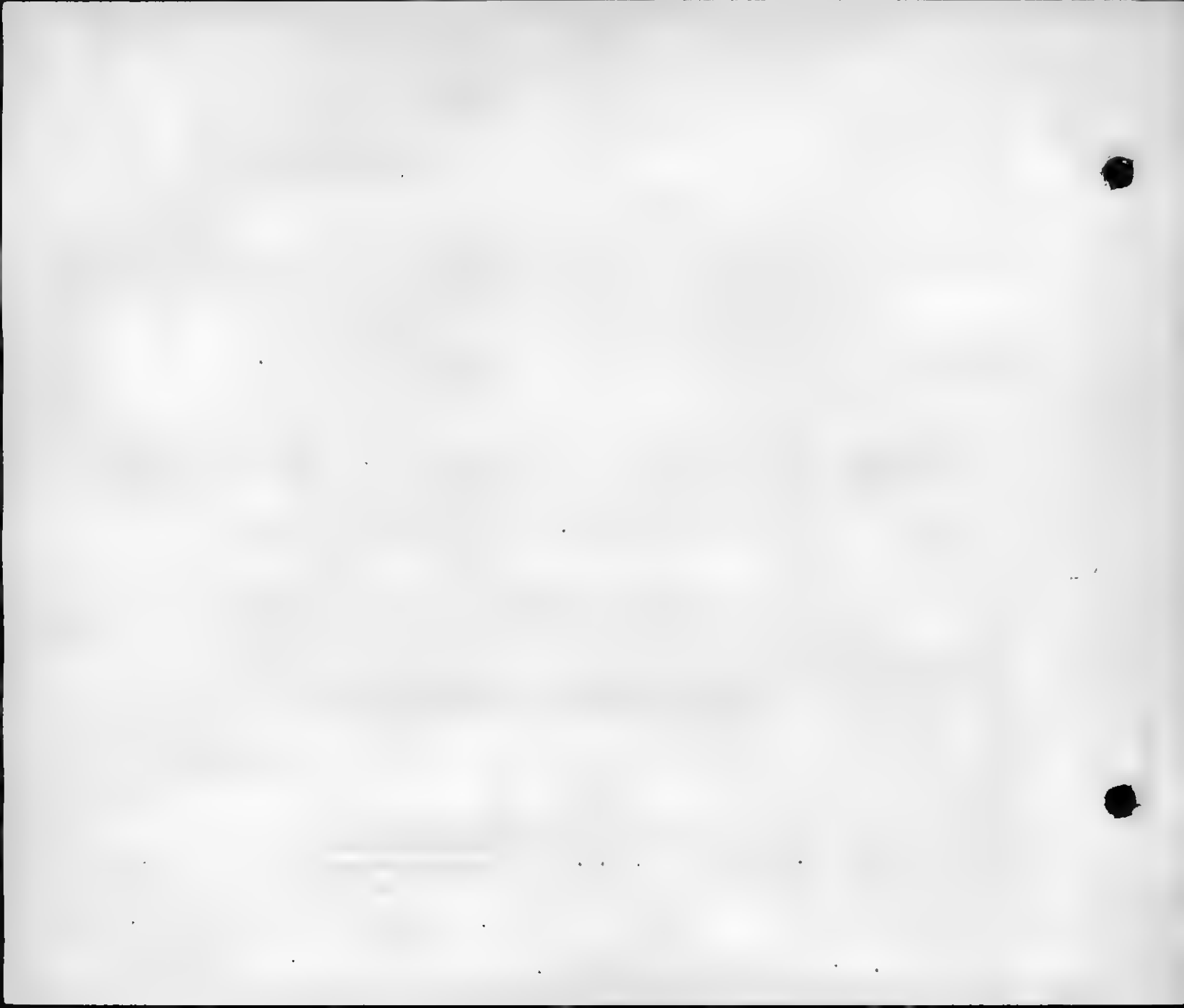
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation or removal, and in any event within 72 hours after death.

21
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 7, Film G241, 4/13/59 fcy

04851
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Hrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1161 Kuhn Ave						e. STREET ADDRESS 802 Umbra St				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM GEORGE KRAMER Sr			First Middle Last			4. DATE OF DEATH April 2 1959			Month Day Year				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jany 26 1910		9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Solicitor				10b. KIND OF BUSINESS OR INDUSTRY Trucking Co		11. BIRTHPLACE (State or foreign country) Baltimore City Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry Kramer						14. MOTHER'S MAIDEN NAME Belle (No Record)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO -----		17. INFORMANT William G. Kramer Jr 802 Umbra St Baltimore City Md				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 4^1 DUE TO Arteriosclerotic coronary heart disease Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None									
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) -		(County) -			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE S. Robert Wells				M. D. S. Robert Wells, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4-3-59	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4/7/59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				22d. LOCATION (City, town, or county) (State) Baltimore County Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman						ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



4850

CERTIFICATE OF DEATH

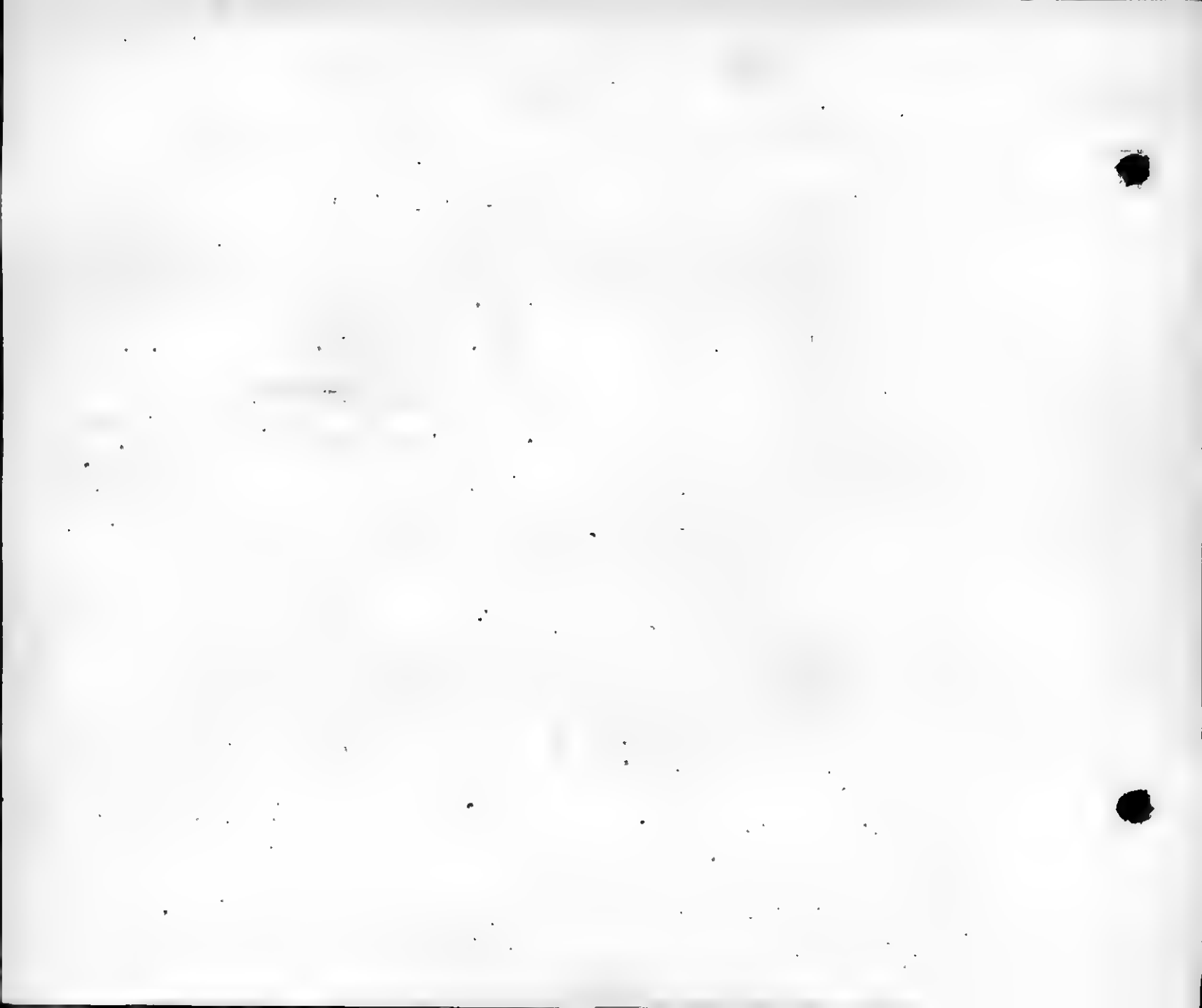
04852

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1546 Dual Highway		d. STREET ADDRESS 1546 Dual Highway	
3. NAME OF DECEASED (Type or print) First Harvey Middle Evers Last Krebs		4. DATE OF DEATH Month April Day 16 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16 1869
9. AGE (In years last birthday) yrs. 89		IF UNDER 1 YEAR Months 7 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner Ret'd		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) St. James Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Krebs	
14. MOTHER'S MAIDEN NAME Tracy Easterday		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Earl Dinsmore Address 1546 Dual Highway Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO year. (b) year. (c) year.			INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) virus infection			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/14 , 19 59 , to 4/16 , 19 59 , that I last saw the deceased alive on 4/16 , 19 59 , and that death occurred at 7:35 PM , from the causes and on the date stated above. ADDRESS (street, city or town, state) 135 No. Potomac St 4/17/59			
ACTUAL SIGNATURE S. J. Bayler		DATE SIGNED 4/17/59	
PHYSICIAN'S NAME (Type) Alfred L. E. Williamsport Md.		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 19-59	22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	22d. LOCATION (City, town, or county) (State) Williamsport Md.
23. FUNERAL DIRECTOR'S SIGNATURE Alfred L. E. Williamsport Md.		24a. REC'D BY REGISTRAR DATE APR 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 22d FilmG242 5-6-59 et

4894

CERTIFICATE OF DEATH

04853

302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R # 6</u>		c. LENGTH OF STAY IN 1b <u>18 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reid</u>		e. STREET ADDRESS <u>Reid Lehman's Mill</u>	
3. NAME OF DECEASED (Type or print) First <u>ESTHER</u> Middle <u>HEEFNER</u> Last <u>LEHMAN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jany 29 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Heefner</u>		14. MOTHER'S MAIDEN NAME <u>Effie Sprengle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-0792</u>	
17. INFORMANT <u>Lester H. Lehman Sr</u>		Address <u>Hagerstown Md. R# 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Nov.</u> 19 <u>58</u> to <u>22 April</u> 19 <u>59</u> , that I last saw the deceased alive on <u>18 April</u> 19 <u>59</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert D. Hoachlander</u>		ADDRESS (Street, city or town, state) <u>115 W. Washington</u>	
PHYSICIAN'S NAME (Type) <u>Robert D. Hoachlander</u>		DATE SIGNED <u>4/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew L. Hoffman, Hagerstown, Md.</u>		24a. REGD. BY REGISTRAR <u>APR 28 59</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4851

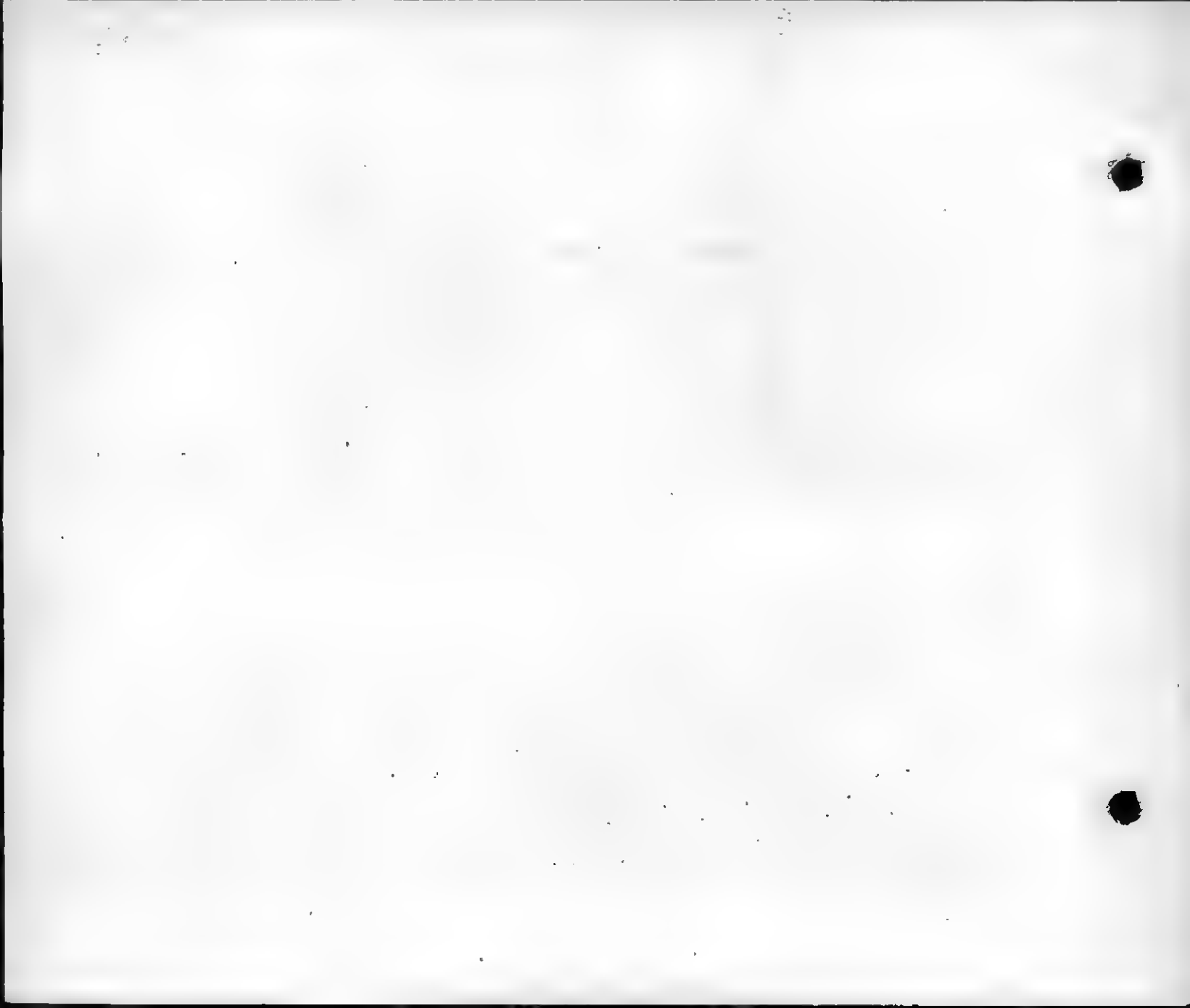
CERTIFICATE OF DEATH

04854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ASH.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN lb <u>3 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>		e. STREET ADDRESS <u>ROUTE 40 WEST</u>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>LOUISE</u> Last <u>LESHER</u>		4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 13, 1914</u>
9. AGE (In years lost birthday) yrs. <u>44</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>ARYLA'D</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL S. McCARTY</u>		14. MOTHER'S MAIDEN NAME <u>ALTA L. ILLS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>214-09-0943</u>	
17. INFORMANT <u>W. HAROLD LESHAR CLEAR SPRING, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>592 X</u> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>CHRONIC GLOMERULONEPHRITIS WITH HYPERTENSION</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>15 YEARS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 2, 1959</u> to <u>APRIL 15, 1959</u> , that I last saw the deceased alive on <u>APRIL 15, 1959</u> , and that death occurred at <u>10:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.			
PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN, M.D.</u>		<u>CLEAR SPRING, MARYLAND</u> <u>APRIL 16, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROOSEVELT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
ADDRESS <u>CLEAR SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4895

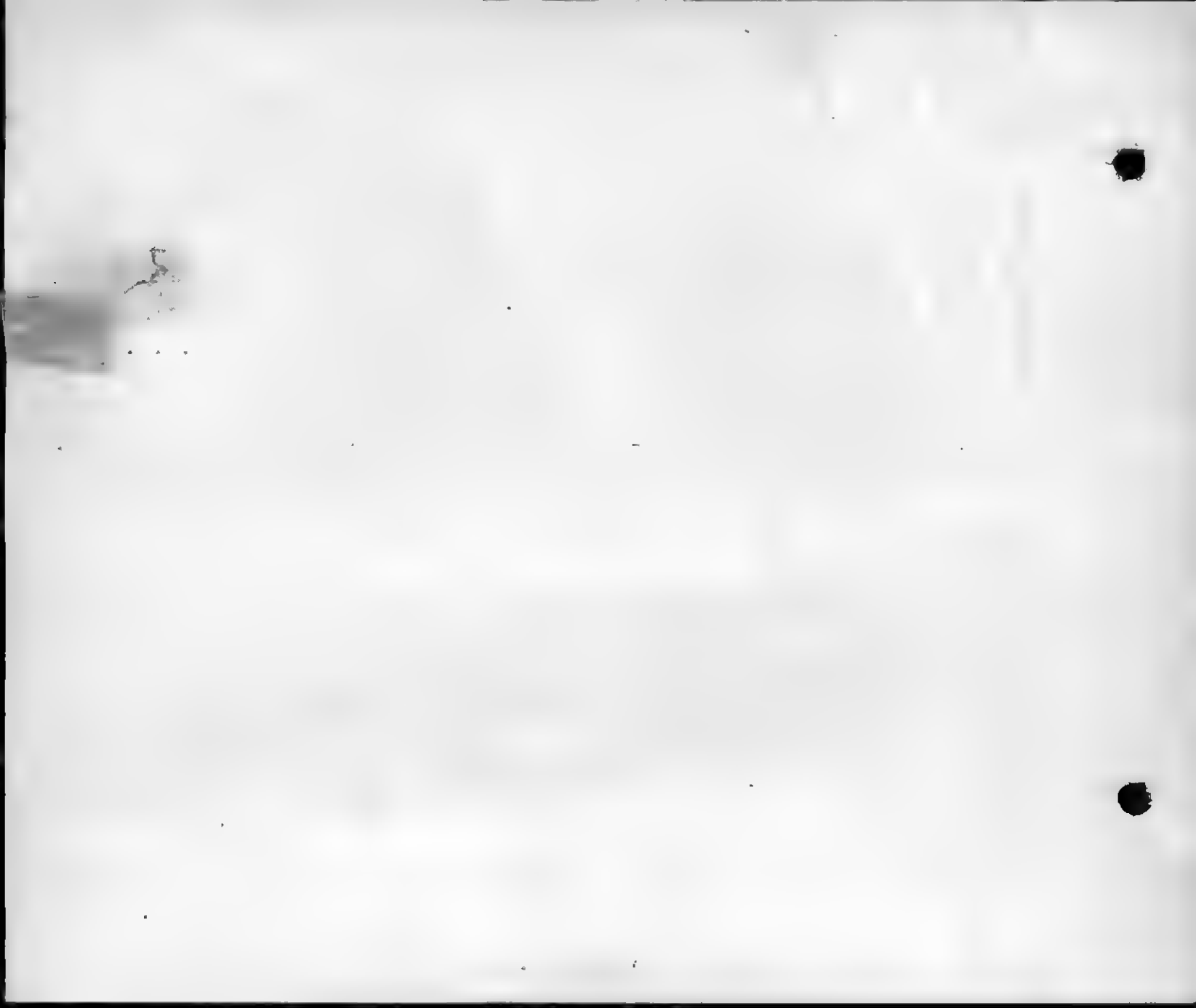
CERTIFICATE OF DEATH

04855

Reg. Dist. No.

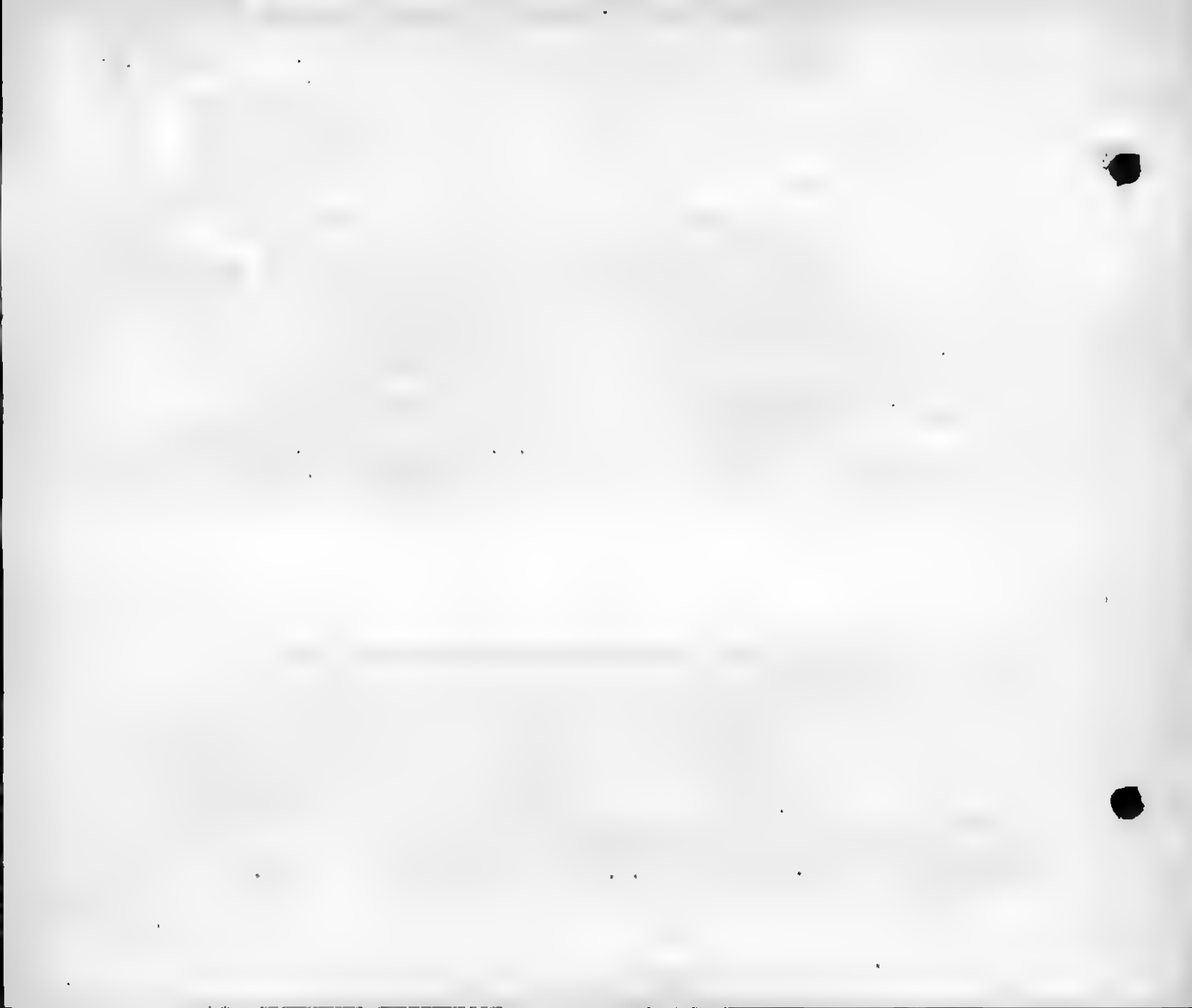
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RURAL CLEAR SPRING, MD RT. 1</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESIDENCE</u>				e. STREET ADDRESS <u>NONE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELMER A LESHNER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 3 1959</u>					
5 SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>DEC. 13, 1889</u>			
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 2+ YRS		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>CLEAR SPRING DISTRICT</u>			
13. FATHER'S NAME <u>ISSAC LESHNER</u>				14 MOTHER'S MAIDEN NAME <u>CATHERINE TICE LESHNER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or date of service) <u>WORLD WAR I</u>				16 SOCIAL SECURITY NO <u>217-09-9585</u>		17 INFORMANT Address <u>ELZIE LESHNER CLEAR SPRING, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>April 3, 1959</u> to <u>April 5, 1959</u> , that I last saw the deceased alive on <u>April 3, 1959</u> , and that death occurred at <u>1:41</u> M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u>					
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>				DATE SIGNED <u>3/6/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>				ADDRESS <u>CLEAR SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 9 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS A15 (4)
15M 10/57

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 11 Wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS Moller Apts		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LENA Middle LOTTIE Last LYON				4. DATE OF DEATH Month April Day 14 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 12 1879	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 19 Min		11. IF UNDER 24 HRS Hours 19 Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Plotle				14. MOTHER'S MAIDEN NAME Rose Kursh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. I. B. Lyon 1500 Penna Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterial embolus, left leg DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 48 hours About 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. Month 19 Day 19 Year 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5 19 45 , to 4-14 19 59 , that I last saw the deceased alive on 4-14-1959 , and that death occurred at 3:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Hornbaker				DATE SIGNED 154 West Washington Street 4:15:59			
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4/16/59		22c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR DATE APR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4853 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 9, Film G241, 4/17/59 fcy

04857

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 130 E. Baltimore Street		e. STREET ADDRESS 130 E. Baltimore Street	
3. NAME OF DECEASED (Type or print) RALPH PAGE MARPEL		4. DATE OF DEATH Month April Day 6 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17 1901
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 3 Days 5	
11. IF UNDER 24 HRS Hours 19 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Makes Blue Prints		10b. KIND OF BUSINESS OR INDUSTRY Fairchild	
11. BIRTHPLACE (State or foreign country) Md. Hagerstown Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur H. Marpel		14. MOTHER'S MAIDEN NAME Camilla Everhart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Jane W. Marpel		Address 130 E. Baltimore St Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4776X Gun shot into skull and brain (32 calibre revolver) DUE TO Conditions, if any, which gave rise to immediate cause (b) --- DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in head	
20c. TIME OF INJURY Month, Day, Year 12:30 p.m. Apr/6 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) in car	20f. (City or town) (County) (State) Hagerstown Wash Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/8/59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. REC'D BY REGISTRAR APR 9 '59	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL CERTIFICATION

I

2

Y



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4854 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04858
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 35 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
f. STREET ADDRESS 28 Broadway		* IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle EDWIN Last MARTIN		4. DATE OF DEATH Month April Day 3 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME John David Martin		14. MOTHER'S MAIDEN NAME Henrietta Hann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 220-30-9611	
17. INFORMANT Mrs. Ethel Martin		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull with intra-cranial hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pedestrian crossing street that was struck by automobile			INTERVAL BETWEEN ONSET AND DEATH 33 days
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pedestrian crossing street that was struck by automobile	
20c. TIME OF INJURY Month, Day, Year 12:40 AM Feb. 28 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/1959	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE APR 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4855

CERTIFICATE OF DEATH

Reg. Dist. No.

04859
302

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 hours		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 382 S. Cleveland Ave.				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KAWANEE		First PAGE		Middle MAYES		Last		4. DATE OF DEATH Month April	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1959		9. AGE (In years last birthday) yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Paige Mayes-	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO none		17. INFORMANT Mr. Richard R. Mayes		Address Hagerstown, Md.		14. MOTHER'S MAIDEN NAME Esther Louise Shaffer	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart disease 754.4 DUE TO No other disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH Birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) Hagerstown, Maryland		(County) (State)	
21. I certify that I attended the deceased from April 20, 1959 , to April 21, 1959 , that I last saw the deceased alive on April 20, 1959 , and that death occurred at 8:55 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Robert F. Keadle		M.D.		ADDRESS (Street, city or town, state) Hagerstown, Maryland				DATE SIGNED 4-22-59	
PHYSICIAN'S NAME (Type) Robert F. Keadle		318 North Potomac Street, Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/1959		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR APR 27 59		24b. REGISTRAR'S SIGNATURE Charles S. Keadle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



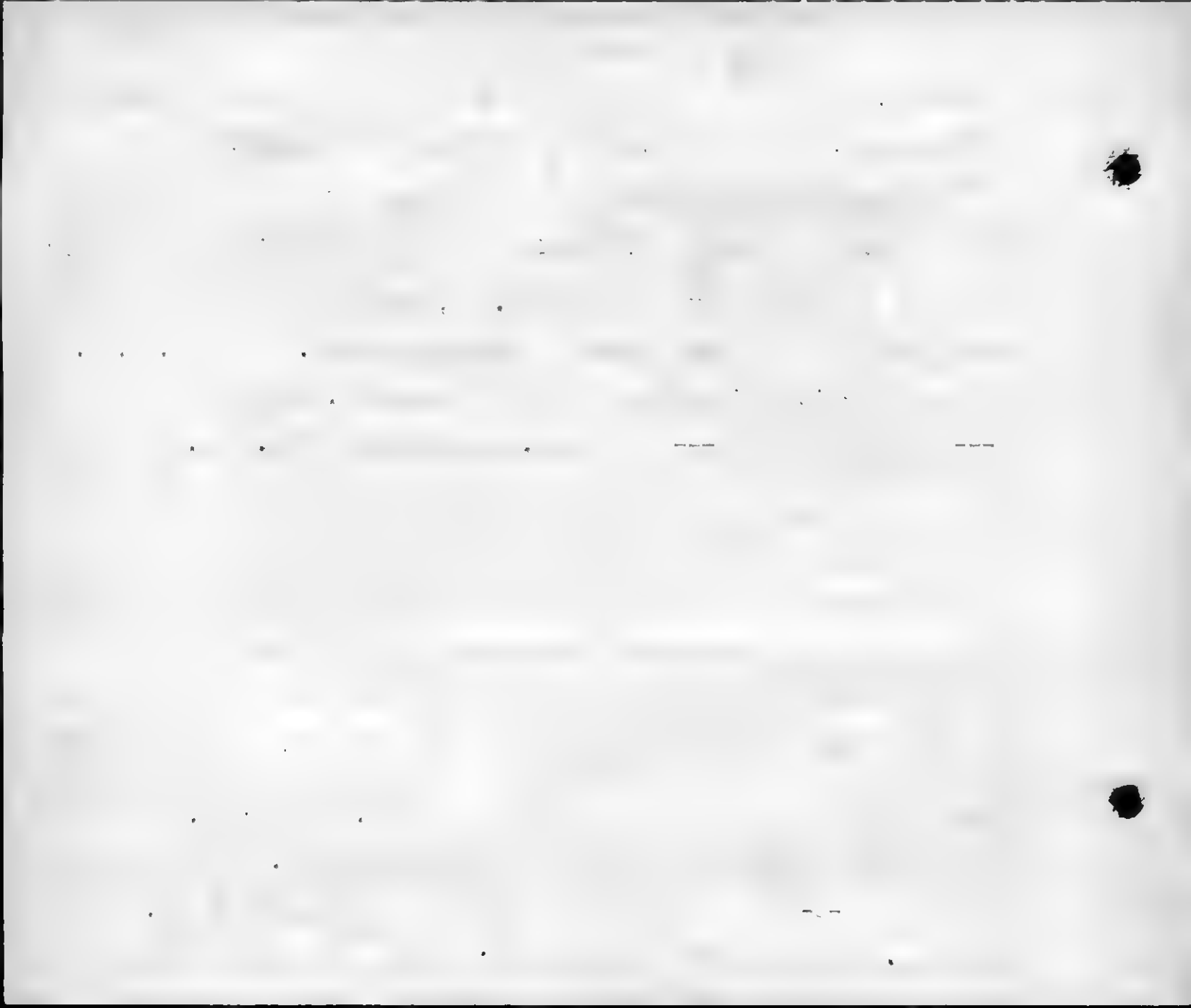
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4856

CERTIFICATE OF DEATH

04860
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 1/2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			
				d. STREET ADDRESS Route 3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edna Senora McCubbin First Middle Last				4. DATE OF DEATH April 3 Month Day Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1885	
				9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Westminster Md.	
13. FATHER'S NAME Jessie Livingston				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -----			
				17. INFORMANT Mrs. Ethel Small Hag. Rt. 3 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF DEATH Month, Day, Year Hour a. 11. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JAN. , 19 58 , to APRIL , 19 59 , that I last saw the deceased alive on 4-3 , 19 59 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 302 N. Potomac St. DATE SIGNED							
ACTUAL SIGNATURE John D. Turco M.D.							
PHYSICIAN'S NAME (Type) John Turco				Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-6-59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md. ADDRESS				24a. REC'D BY REGISTRAR APR 6 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Friend	



CERTIFICATE OF DEATH

04861

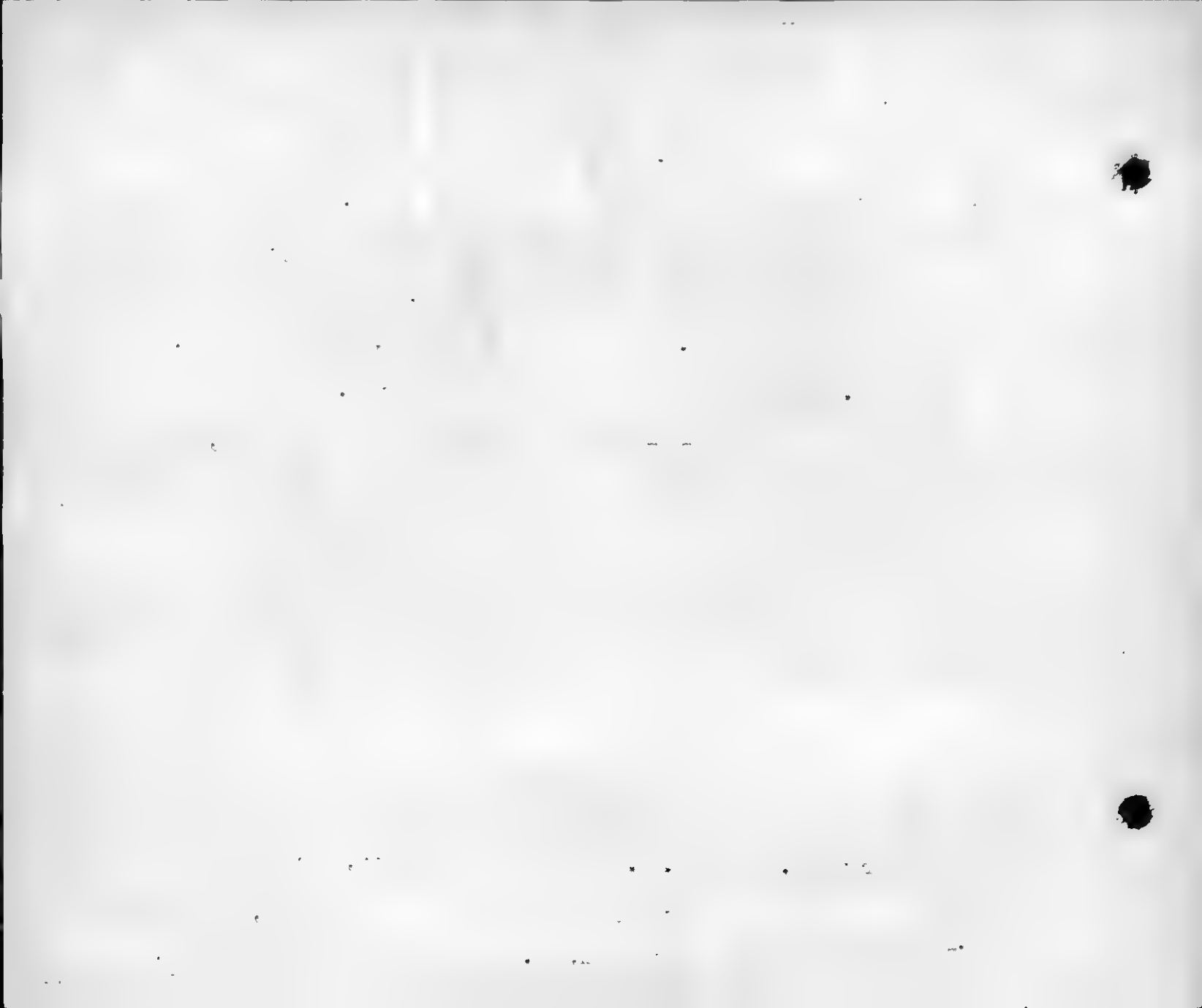
Reg. Dist. No. 302

4857

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home		d. STREET ADDRESS 11 West Antietam Street	
3. NAME OF DECEASED (Type or print) First ELVA Middle GRACE Last MIDDLEKAUFF		4. DATE OF DEATH Month April Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 14, 1866
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph A. Middlekauff		14. MOTHER'S MAIDEN NAME Mary E. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 214-14-6676A	
17. INFORMANT LeRoy Heard		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular Disease 443X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 6 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 19 58 to April 13, 19 59 , that I last saw the deceased alive on April 11th , 19 59 , and that death occurred at 3:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 13820 Washington St. DATE SIGNED _____ ACTUAL SIGNATURE Ernest F. Poole M.D. PHYSICIAN'S NAME (Type) Ernest F. Poole M. D. Hagerstown, Maryland			
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/15/ 1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home 15 Suter-Rouzer		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR APR 16 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



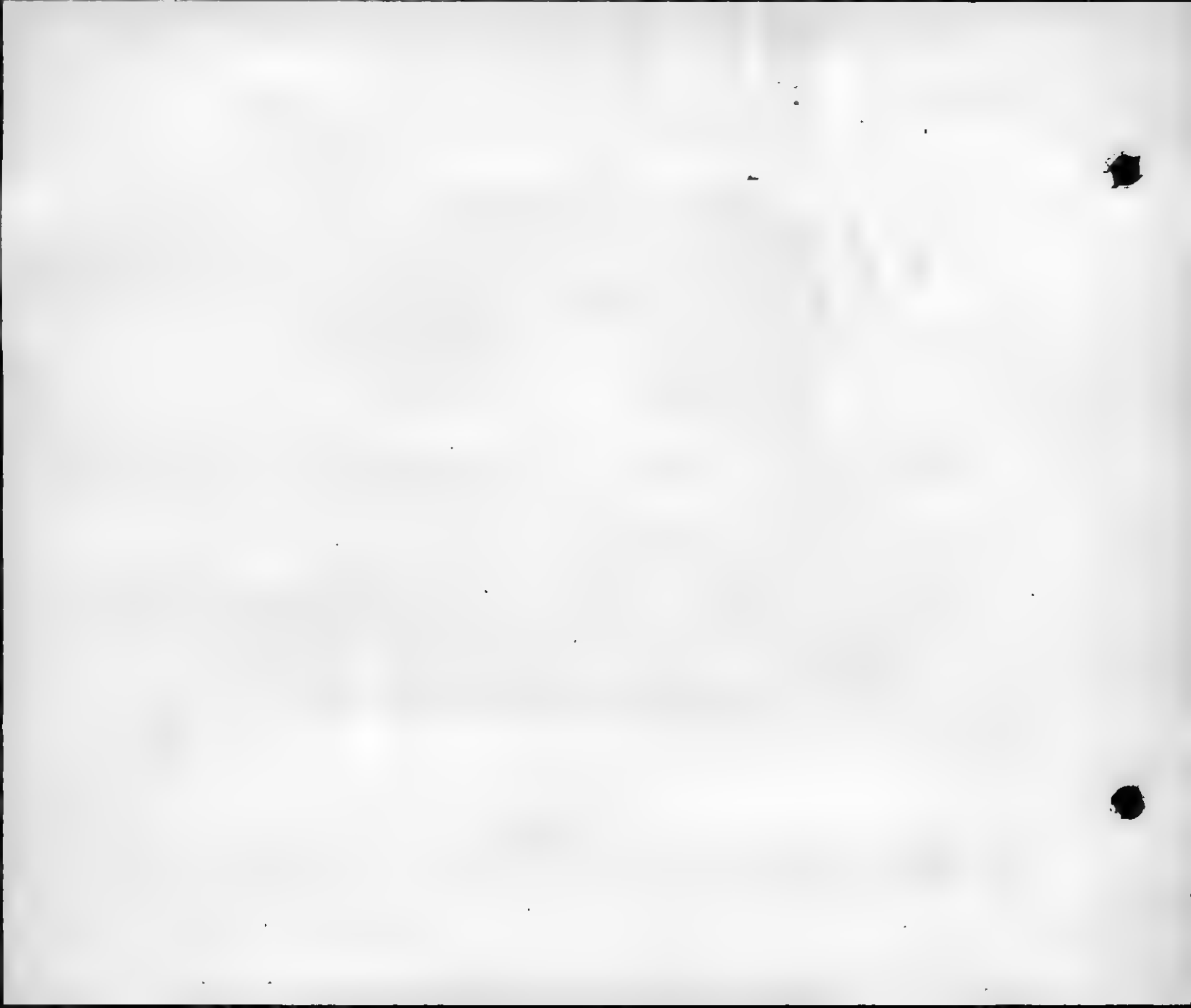
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4858
CERTIFICATE OF DEATH

04862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>9 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH RAY MITCHELL</u>		4. DATE OF DEATH Month Day Year <u>APRIL 20 - 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 9, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>ZITTLTOWN WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE MITCHELL</u>		14. MOTHER'S MAIDEN NAME <u>ANN ZITTLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>215-36-7218</u>	
17. INFORMANT <u>MRS. ETHEL MITCHELL</u>		Address <u>BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart D</u> -DUE TO- (b) <u>Recent Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Aneurysm of ventricle due to</u> -DUE TO- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decomposition of lungs</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>Jan 11 - 1959</u> <u>1 yr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 11</u> , 19 <u>59</u> , to <u>April 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 20</u> , 19 <u>59</u> , and that death occurred at <u>8:35 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington Md</u> DATE SIGNED <u>4-22-59</u>	
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 24 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bart</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	



4896

CERTIFICATE OF DEATH

04863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>				c. LENGTH OF STAY in 1b <u>LIFE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTH MAIN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>PEARL AGNES MORGAN</u>				4. DATE OF DEATH <u>APRIL - 5 - 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT-7-1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		11. BIRTHPLACE (State or foreign country) <u>2 LITTLESTOWN WASH. CO. MD. USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEWIS JONES</u>				14. MOTHER'S MAIDEN NAME <u>MARY KAUFFMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>JOHN F. MORGAN</u> Address <u>BOONSBORO MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>59</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>April 2 - 1959</u> , to <u>April 5 - 1959</u> , that I last saw the deceased alive on <u>April 2 - 1959</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>4/6/59</u> ACTUAL SIGNATURE <u>G. W. Holman</u> M.D. <u>Boonsboro</u> PHYSICIAN'S NAME (Type) <u>G. W. Holman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 8 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u> ADDRESS <u>Boonsboro Md</u>				24a. REC'D BY REGISTRAR <u>DATE APR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

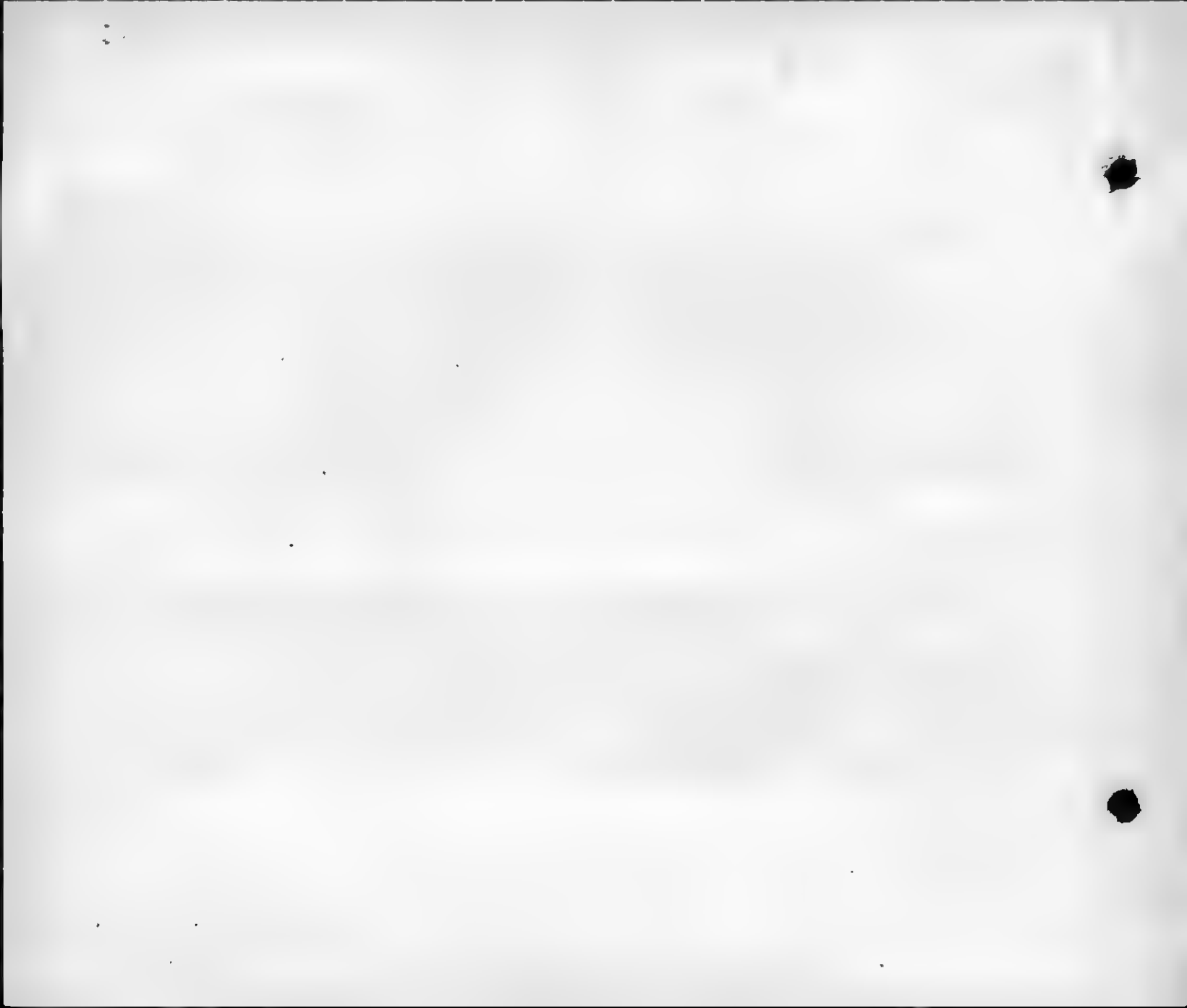
4859

CERTIFICATE OF DEATH

Reg. Dist. No.

04864
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Penna</u> COUNTY <u>Fulton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN TB <u>3 Mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>OLIVE</u> Middle <u>PEARL</u> Last <u>MOUSE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1959</u> 19	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 20 1889</u> 69 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Fulton County Pa.</u>
13. FATHER'S NAME <u>William Vantz</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Shaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO <u>22030-8876</u>	
17. INFORMANT <u>William T. Mouse</u>		Address <u>801 Rolling Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>10 yrs.</u> (c) <u>-----</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4/4</u> , 19 <u>59</u> , and that death occurred at <u>12:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D.J. Boyer</u> M.D.		DATE SIGNED <u>4/6/59</u>	
PHYSICIAN'S NAME (Type) <u>D.J. Boyer 135 No Potomac St</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		24. REC'D BY REGISTRAR <u>APR 8 '59</u>	
ADDRESS <u>Hagerstown /Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hand</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04865

CERTIFICATE OF DEATH

Reg. Dist. No.

4850

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 13 YEARS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2221 PENNSYLVANIA AVE.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 2221 PENNSYLVANIA AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLEMMIE MAY MULLENDORE		4. DATE OF DEATH Month Day Year APRIL - 9 - 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE - 28 - 1876
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	11. BIRTHPLACE (State or foreign country) NR. BOONSBORO WASH. Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN H. HUTZELL	
14. MOTHER'S MAIDEN NAME LAURA STEVENS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address 2221 PENN AVE. HAGERSTOWN MD. NORMAN B. MULLENDORE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease 4. 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 10 yrs. (c) 10 yrs.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 9/1/59 , 19___, to 4/9/59 , 19___, that I last saw the deceased alive on 4/8/59 , 19___, and that death occurred at 1:00 A.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE W.C. Brewer, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Greencastle, Pa. 4/11/59	
PHYSICIAN'S NAME (Type) W.C. Brewer, M.D.		Greencastle, Pa.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL - 12 - 1959	22c. NAME OF CEMETERY OR CREMATORY ROCKERSVILLE CEMETERY	22d. LOCATION (City, town, or county) (State) ROCKERSVILLE WASH. Co. MD
23. FUNERAL DIRECTOR'S SIGNATURE John H. Best		ADDRESS Boonsboro MD.	
24a. REC'D BY REGISTRAR DATE APR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 1

may be retained by the hospital or attending physician.

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. W. C. BREWER
GREENCASTLE, PA.



CERTIFICATE OF DEATH

04866

Reg. Dist. No.

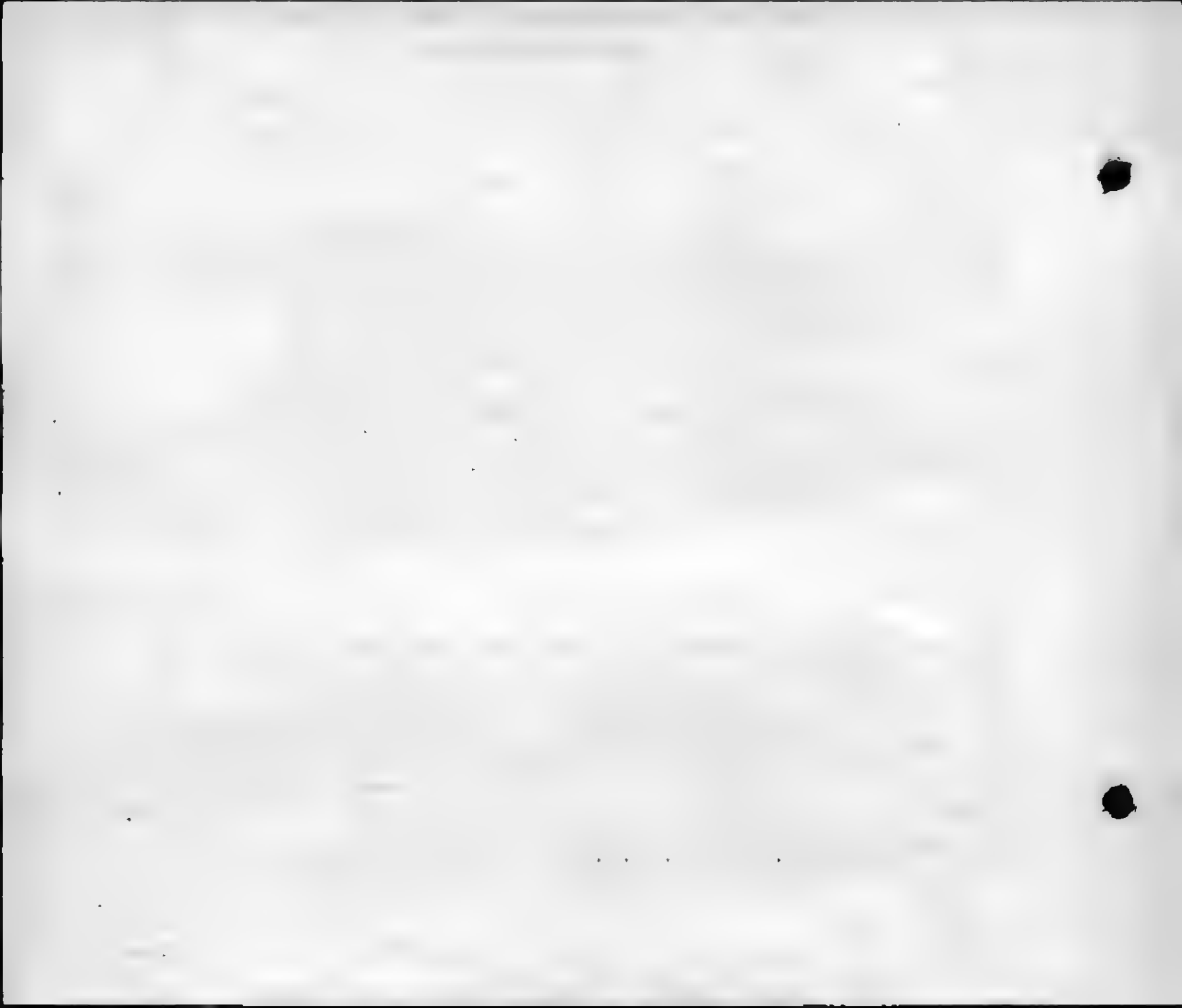
4861

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 205 Summer St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE MAY MUNDEY		4. DATE OF DEATH Month Day Year April 8 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Moore		14. MOTHER'S MAIDEN NAME Martha Susan Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. W. E. Holland Summit & Surrey Ave.		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) unknown INTERVAL BETWEEN ONSET AND DEATH 10 mins.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1959, to April 8, 1959, that I last saw the deceased alive on April 8, 1959, and that death occurred at 12:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. 100 Professional Arts Bldg. 4/10/59			
ACTUAL SIGNATURE William T. Layman, M.D.		PHYSICIAN'S NAME (Type) William T. Layman, M.D. Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/11/59	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 13 59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

Wm. A. Hume C. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4862

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL (If not in hospital, give street address) Garlock Memorial Convalescent Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, d. STREET ADDRESS 1082 Marshall Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bertie Roseanna Nogle First Middle Last 4. DATE OF DEATH April 23 1959 Month Day Year				5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH August 13, 1874 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Frederick County, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Samuel Six 14. MOTHER'S MAIDEN NAME Lucrettia Staley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No 16. SOCIAL SECURITY NO None 17. INFORMANT Mrs. Bessie Carbaugh Address 1082 Marshall St. Hagerstown, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intraabdominal & vertebral metastases 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of sigmoid DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 months 2 years & 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic & hypertensive cardiovascular disease 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that I attended the deceased from August 1956 to April 22 1959 , that I last saw the deceased alive on April 22 1959 , and that death occurred at 5:50 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 100 Professional Arts Bldg., Hagerstown, Maryland DATE SIGNED 4/23/59			
ACTUAL SIGNATURE Wm. T. Layman PHYSICIAN'S NAME (Type) William T. Layman, M. D.,				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4-26-59 22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery 22d. LOCATION (City, town, or county) (State) Thurmont, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager ADDRESS Thurmont, Md.				24a. REC'D BY REGISTRAR DATE APR 28 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE Maryland b COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X R # 5 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Smithsburg, Maryland		d STREET ADDRESS R # 5	
3. NAME OF DECEASED (Type or print) Merle Edward Overcash		4. DATE OF DEATH April 19 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/4/1914
9. AGE (In years last birthday) 44 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason	
11. BIRTHPLACE (State or foreign country) Rouzerville Pa.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Overcash		14. MOTHER'S MAIDEN NAME Catherine Rowe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War 2		16. SOCIAL SECURITY NO. 218-01-8826	
17. INFORMANT Ivan Overcash, Chambersburg Pa., #5		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 973.1 Carbon Monoxide poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (State) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Connected exhaust pipe to interior of car	
20c. TIME OF INJURY Month, Day, Year Hour X 3 p.m. Apr. 19 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Reservoir property		20f. (City or town) Rural Smithsburg Wash Md (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/59	
22c. NAME OF CEMETERY OR CREMATORY Harbaugh's		22d. LOCATION (City, town, or county) Smithsburg #2, Franklin Pa. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Washington Pa.		24a. REC'D BY REGISTRAR APR 27 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. c. LENGTH OF STAY IN 1b 12 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Foundry St.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. d. STREET ADDRESS 46 S. Mulberry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Franklin Last Rhodes			4. DATE OF DEATH Month April Day 29 Year 19 59				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7 1891	9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months 5 Days 21 IF UNDER 24 HRS: Hours Min. 	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor 10b. KIND OF BUSINESS OR INDUSTRY Building Contractor 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME John L. Rhodes			14. MOTHER'S MAIDEN NAME Mary Elizabeth Godsard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 05 6289		17. INFORMANT Address Mr. Clinton Rhodes Williamsport Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coronary heart disease DUE TO Acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					INTERVAL BETWEEN ONSET AND DEATH 		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> none					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -none		
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none 20f. (City or town) (County) (State) 			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE S. Robert Wells EXAMINER'S NAME (Type) S. Robert Wells, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF May 2-59		22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport Md			24a. REC'D BY REGISTRAR MAY 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hana		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



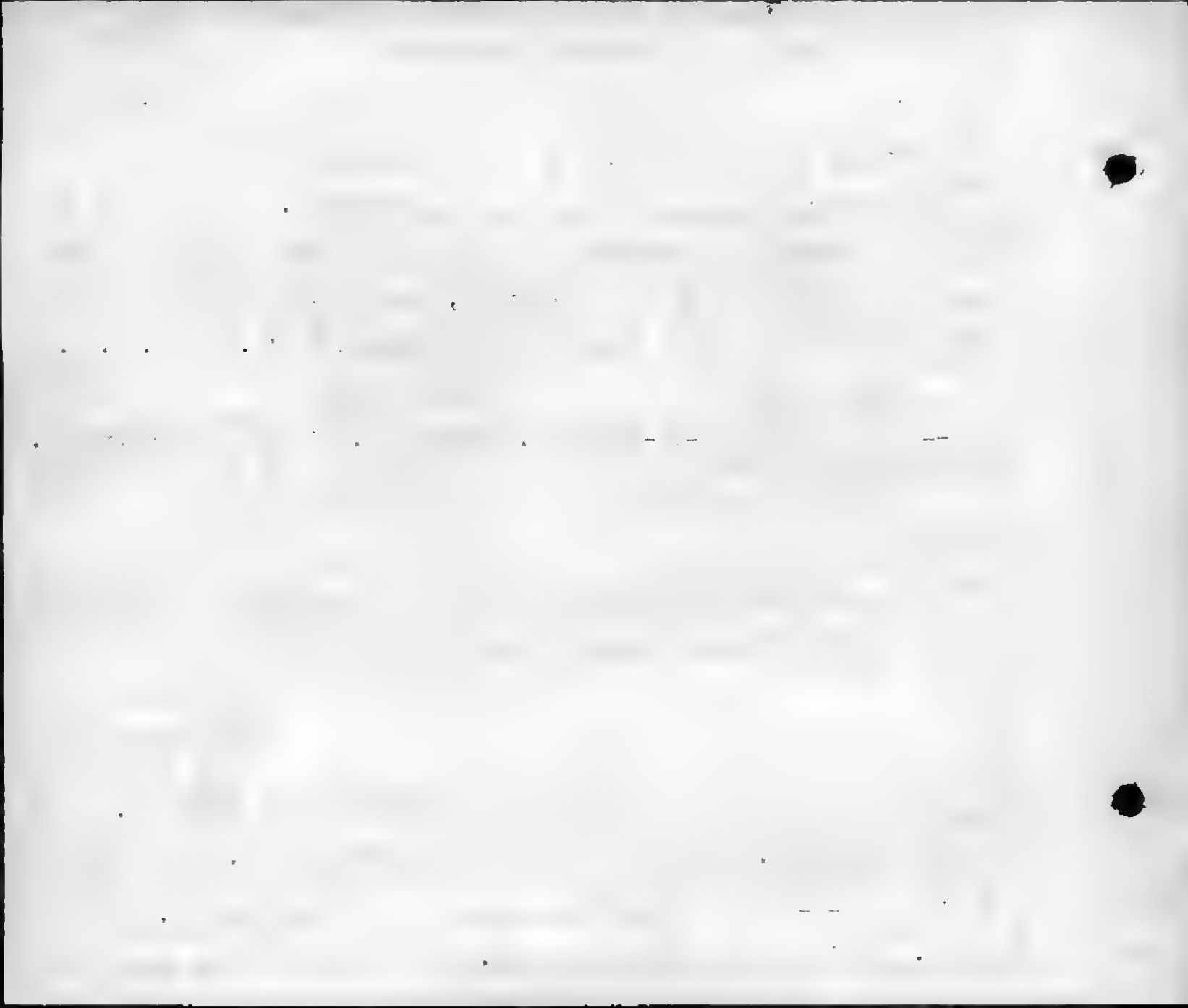
4864

CERTIFICATE OF DEATH

04870

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 62 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 213 Summer St		f. STREET ADDRESS 213 Summer St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle Roseanna Last Rice		4. DATE OF DEATH Month April Day 5 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1884
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Near Winchester Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James M Lamp		14. MOTHER'S MAIDEN NAME Mary Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-09-2583	
17. INFORMANT Mrs. Margaret L. Wiles		Address Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 8 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1946 , to Apr 5, 1959 , that I last saw the deceased alive on Apr 5, 1959 , and that death occurred at 137 West Washington St. M, from the causes and on the date stated above.		DATE SIGNED 4-6-59	
ACTUAL SIGNATURE Robert P. Conrad M.D.		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) Robert P. Conrad		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-7-59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		24a. REC'D BY REGISTRAR DATE APR 8 '59	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hane	



4865

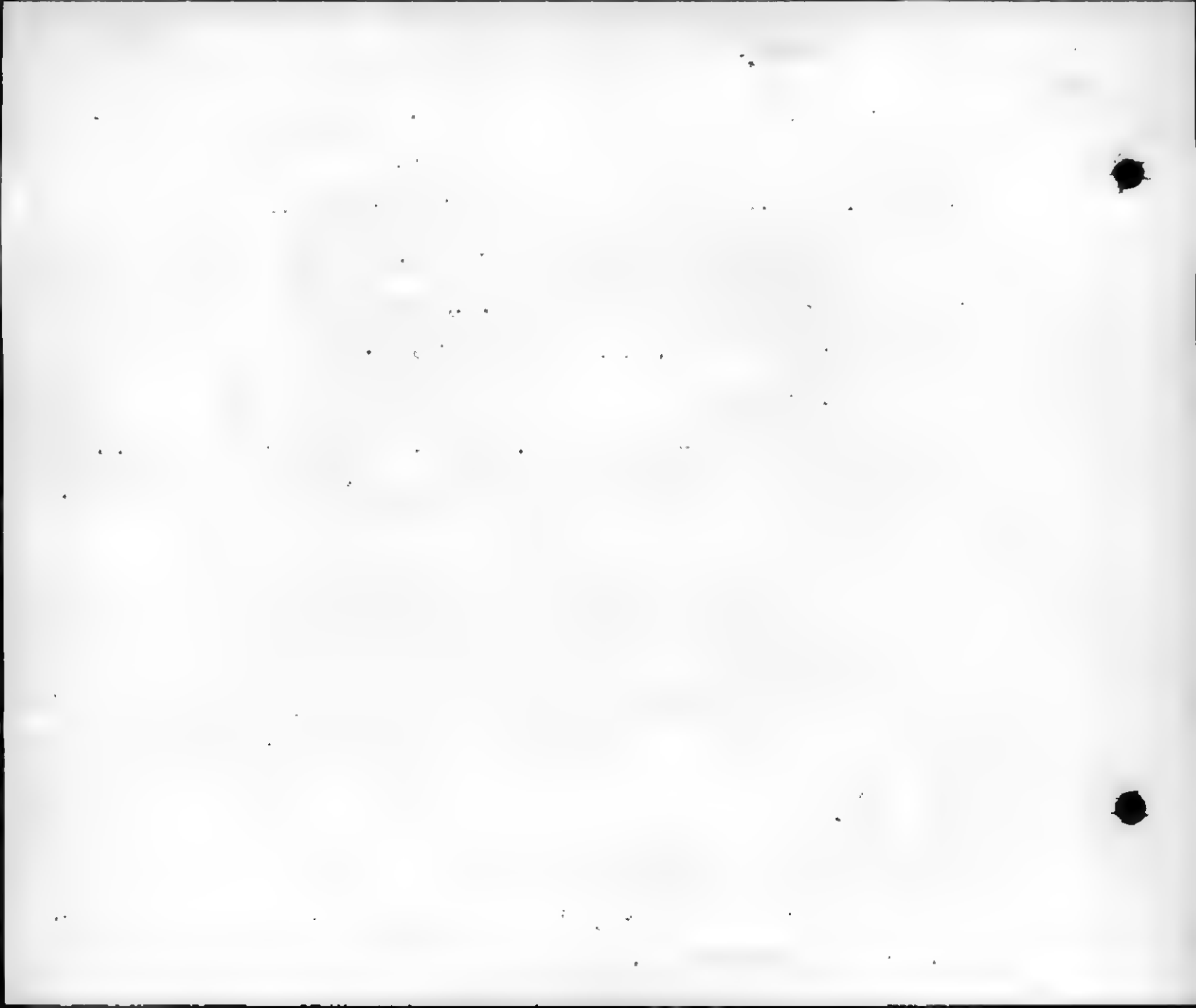
CERTIFICATE OF DEATH

04871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 58 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 Roessner Ave.,		d STREET ADDRESS 110 Roessner Ave.,	
3. NAME OF DECEASED (Type or print) First James Middle B Last Rickard Sr.		4. DATE OF DEATH Month 4 Day 6 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1884
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired conductor		10b. KIND OF BUSINESS OR INDUSTRY Penn. R.R.	
11. BIRTHPLACE (State or foreign country) Luray, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Rickard		14. MOTHER'S MAIDEN NAME Rebecca Judd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. 716-03-2077A	
17. INFORMANT Mrs. Grace L. Rickard		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Codensity Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/6/59 , 19 59 , to 4/6/59 , 19 59 , that I last saw the deceased alive on 4/6/59 , 19 59 , and that death occurred at 11:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/7/59			
ACTUAL SIGNATURE Fred W. Kraiss		M.D. William J. ...	
PHYSICIAN'S NAME (Type) Fred W. Kraiss			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4-9-59	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE APR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4866

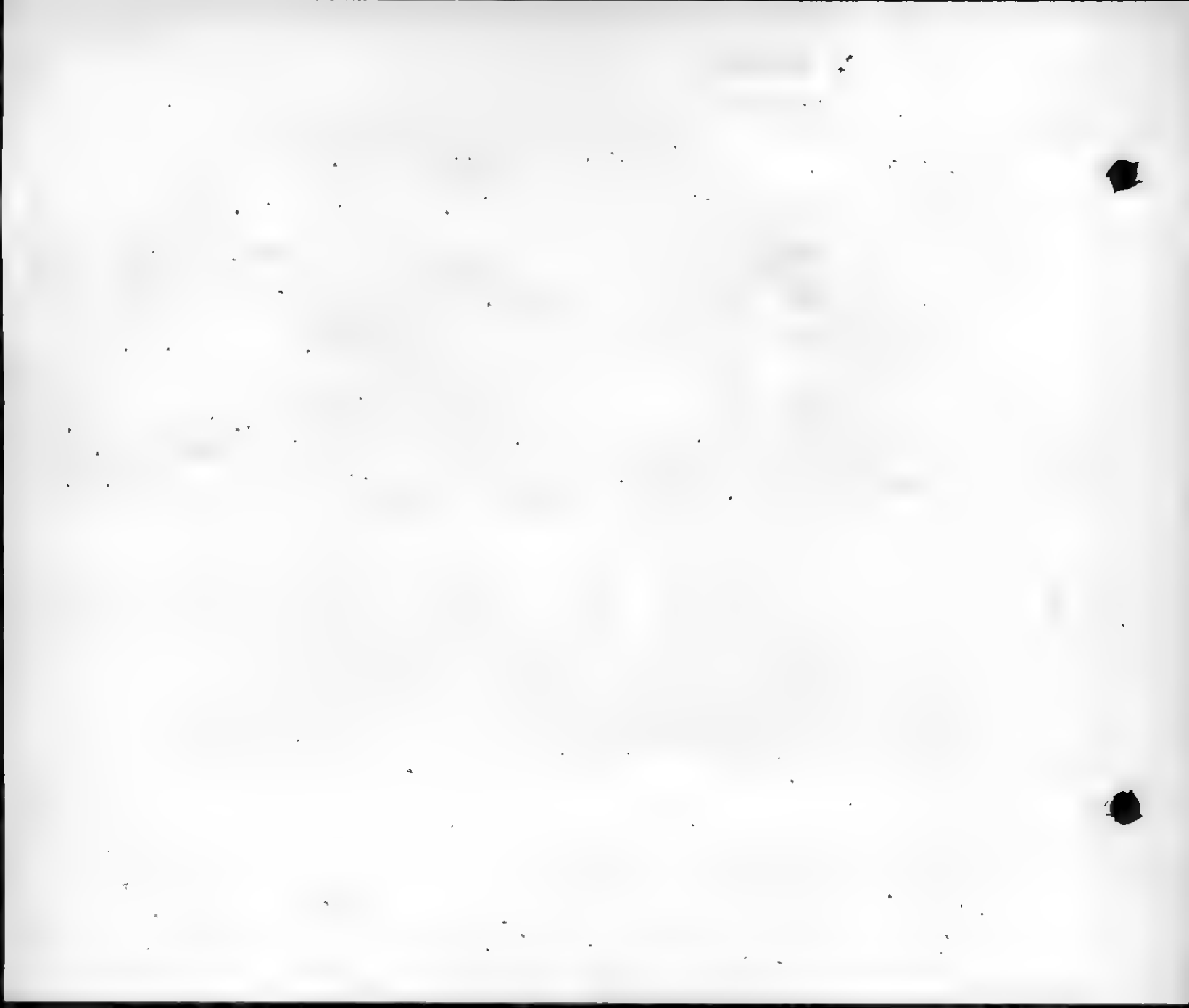
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				c. LENGTH OF STAY IN 1b 10 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. 03			
f. STREET ADDRESS 328 S. Cleveland Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Annie Middle Last Shipley				4. DATE OF DEATH Month April Day 12 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5 1885	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months 5 Days 8	IF UNDER 24 HRS Hours 8 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Downsville Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Levi Cline				14. MOTHER'S MAIDEN NAME Martha Detrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. George Lizer Address 116 W. Potomac St. Williamsport Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH May	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/12/59 19, to 4/12/59 19, that I last saw the deceased alive on 4/12/59 19, and that death occurred at 11 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert L. Young M.D. Williamsport Md. 4/13/59							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 15-59		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Wolf Williamsport Md.				24a. REC'D BY REGISTRAR DATE APR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

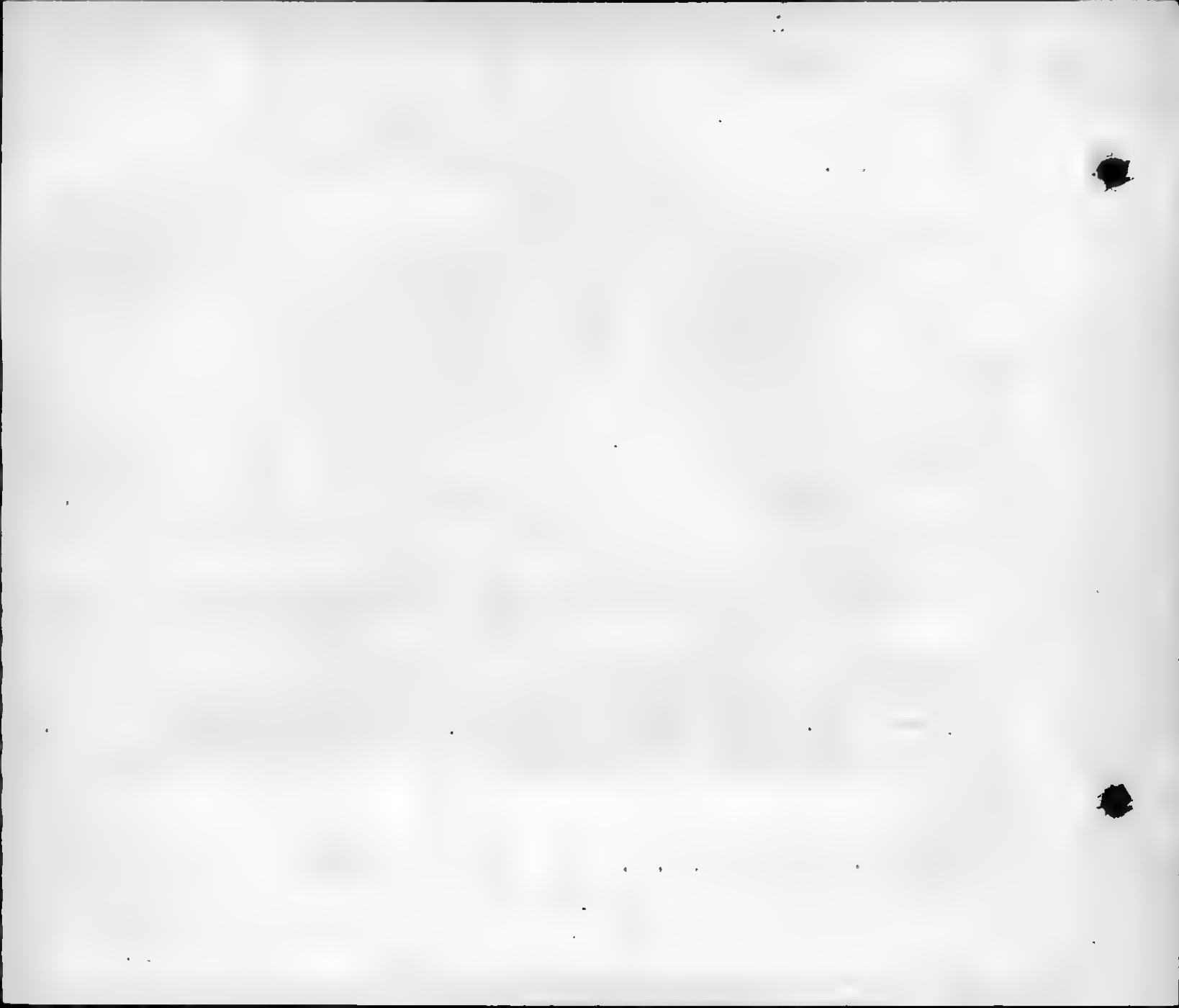
04873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Pa. RR & Nursery Rd		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pinal - Chambersburg, Pa.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 12. 10. 4 7. x	
3. NAME OF DECEASED (Type or print) Donald E Shuman		4. DATE OF DEATH April 11 1959	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1929
9. AGE (In years last birthday) 29 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route supervisor		12. KIND OF BUSINESS OR INDUSTRY Capital Bankers, Inc	
13. FATHER'S NAME Harold J. Shuman		14. MOTHER'S MAIDEN NAME Alice Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 186-24-7676	
17. INFORMANT Mrs. Isabel S. Shuman - R.R. 4		Address Chambersburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull(open) DUE TO Multiple fractured Ribs Conditions, if any, which gave rise to immediate cause (b) Fractured femur(left) (a), stating the underlying cause lost, DUE TO Hemorrhage and shock (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driving truck and struck by train at RR crossing	
20c. TIME OF INJURY Month, Day, Year 4 10 5 p.m. Apr. 11, 59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursery Rd.		20f. (City or town) Hagerstown (County) Wash. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		DATE SIGNED April 12 1959	
EXAMINER'S NAME (Type) S. Robert Wells, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/59	
22c. NAME OF CEMETERY OR CREMATORY St Thomas		22d. LOCATION (City, town, or county) St Thomas, Pa. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert P. Barber		ADDRESS Chambersburg, Pa.	
24a. REC'D BY REGISTRAR APR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

MEDICAL CERTIFICATION

2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

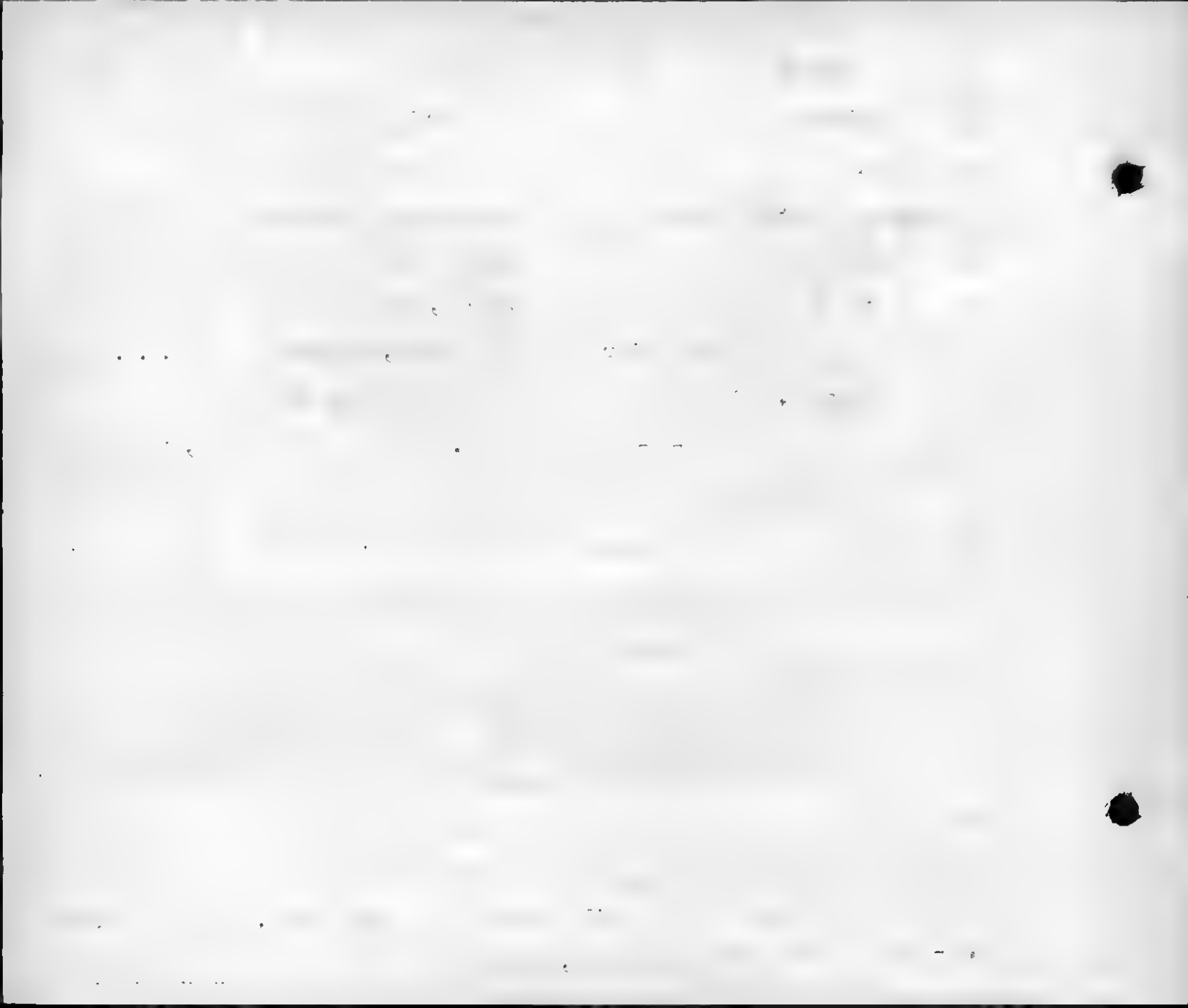
04874
Reg. Dist. No. 302

4868

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN It 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) HARRY First LEE Middle SLICK Last		4. DATE OF DEATH Month April Day 17 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1893
9. AGE (In years last birthday) 65 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat Packer	11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Slick	
14. MOTHER'S MAIDEN NAME Emma Florence Stouffer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO 176-05-2599		17. INFORMANT Address Robert K. Slick Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Hypertensive Cardiac Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 21 days 10 yrs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1949 19____ to 17 Apr 19 59 that I lost sows the deceased alive on 16 am 19 59 and that death occurred at 5:10 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE F. F. Lusby		ADDRESS (Street, city or town, state) 2301 Potomac St Hagerstown Md DATE SIGNED 18 Apr 59	
PHYSICIAN'S NAME (Type) F. F. Lusby			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/19/1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		24a. REC'D BY REGISTRAR DATE APR 22 '59	
ADDRESS Hagerstown, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4869

CERTIFICATE OF DEATH

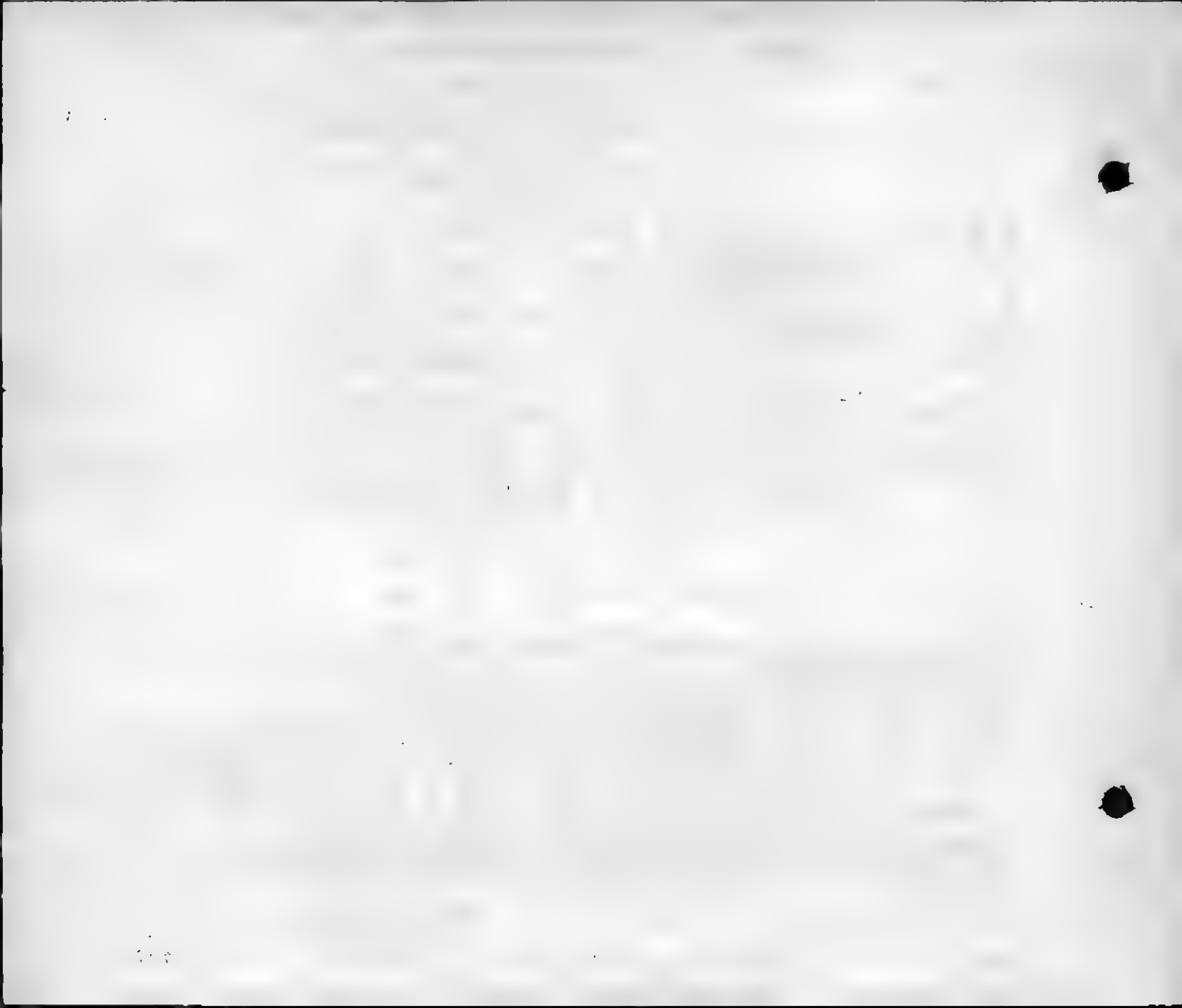
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>5 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON COUNTY HOSPITAL</u>		e. STREET ADDRESS <u>SMITHSBURG MD R.1</u>	
3. NAME OF DECEASED (Type or print) First <u>TERRY</u> Middle <u>LYNN</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL-2-1959</u>
9. AGE (In years lost birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>THURMAN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>CLERY SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>THURMAN SMITH</u>		Address <u>SMITHSBURG MD. R.1</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Myocardial</u> (c) <u>infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>April</u> Day <u>7</u> Year <u>1959</u> Hour a. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>59</u> , to <u>April 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 7</u> , 19 <u>59</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Sidney Hoverson</u> M.D. <u>—</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY HOVERSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL-9-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAHRNEY'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MAPLEVILLE WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bass</u>		ADDRESS <u>Boonsboro Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

2081193XV7



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AT5ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hancock</u> d. STREET ADDRESS <u>!</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>B</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/95</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis B. Mann</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Guy Benjamin Snyder</u> Address <u>Hancock R.F.D.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes m.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1945</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis 1956</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>Apr. 13-59</u>	
EXAMINER'S NAME (Type) <u>S. ROBERT WELLS, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-59</u>	
22c. NAME OF CEMETERY OR CHURCH <u>Orchard Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Hancock Wash. Co. md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Howe Hancock md</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>APR 15 59</u>		24b. REGISTRAR'S SIGNATURE <u>Carling L. Howe</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 3241 4-27-59 et

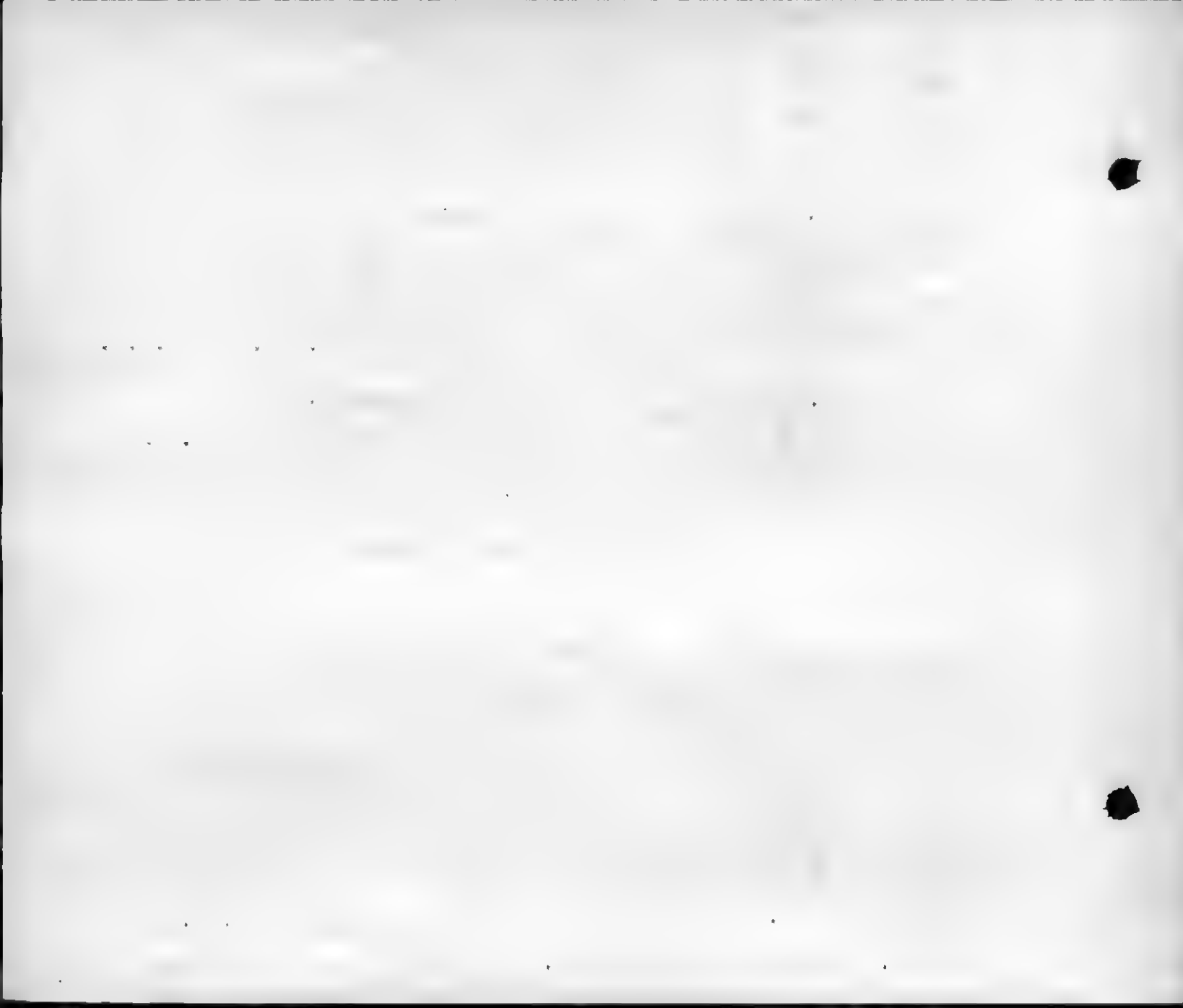
CERTIFICATE OF DEATH

4870

Reg. Dist. No.

04878
303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN It 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
f. STREET ADDRESS 338 S. Locust St.		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Palmer Spedden		4. DATE OF DEATH Month April Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14/1875
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader		12. KIND OF BUSINESS OR INDUSTRY Retired	
13. BIRTHPLACE (State or foreign country) Washington Co. Md.		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME William E. Spedden		16. MOTHER'S MAIDEN NAME Marie S. Davis	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No If yes, give year or date of service None		18. SOCIAL SECURITY NO	
19. INFORMANT Claude Potterfield		Address 415 Va. Ave.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Acute Pneumonia Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Intermittent Acute (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1, 1959 to April 13, 1959 , that I last saw the deceased alive on April 13, 1959 , and that death occurred at 9:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Hevian		DATE SIGNED 4/15/59	
PHYSICIAN'S NAME (Type) G. W. Hevian		ADDRESS (Street, city or town, state) 1302 Westmoreland Ave. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/15/59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR APR 21 '59		24b. REGISTRAR'S SIGNATURE C. H. H. H.	



4871

CERTIFICATE OF DEATH

04879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 52 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 439 W. Church St.,		d. STREET ADDRESS 439 W. Church St.,	
3. NAME OF DECEASED (Type or print) First Anna Middle G Last Spessard		4. DATE OF DEATH Month 4 Day 22 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1887
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Rocky Ridge, Fred. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Gilbert		14. MOTHER'S MAIDEN NAME Eliza Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles H. Spessard		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 19 55 to 22 Apr 19 59 that I last saw the deceased alive on 21 Apr 19 59 and that death occurred at 6:50 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2301 Potomac Hagerstown Md. DATE SIGNED 22 Apr 59			
ACTUAL SIGNATURE F. F. Lusby		M.D. 2301 Potomac Hagerstown Md.	
PHYSICIAN'S NAME (Type) F. F. Lusby			
22a. BURIAL, CREMATION, RENOVATION (Specify) burial	22b. DATE THEREOF 4-25-59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR APR 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4899

CERTIFICATE OF DEATH

04880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CLEAR SPRING		c. LENGTH OF STAY IN 1b 89 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) ROUTE 40		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle S. Last SPICKLER		4. DATE OF DEATH Month 4 Day 27 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1869
9. AGE (In years last birthday) 89 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS A. SPICKLER		14. MOTHER'S MAIDEN NAME REBECCA P. SHARPLESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FRANK A. SPICKLER		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE STOMACH WITH METASTASIS DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
ANEMIA, DUE TO CHRONIC BLOOD LOSS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 22, 1959 to APRIL 27, 1959 , that I last saw the deceased alive on APRIL 27, 1959 , and that death occurred at 11:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.			
PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		CLEAR SPRING, MARYLAND APRIL 28, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/30/59	22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY	22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK		ADDRESS CLEAR SPRING, MD.	24a. REC'D BY REGISTRAR DATE APR 29 '59
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4900

CERTIFICATE OF DEATH

04881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. LENA RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOONSBORO MD. R. 2</u>		d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CESSE</u> Middle <u>M</u> Last <u>STINE</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER - BUILDING CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUNKER HILL W.VA. U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID STINE</u>		14. MOTHER'S MAIDEN NAME <u>CLARA BAKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-6314</u>	
17. INFORMANT <u>MRS. GLADYS STINE</u>		Address <u>BOONSBORO MD. R. 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 yds.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 28, 1959</u> to <u>April 28, 1959</u> , that I last saw the deceased alive on <u>April 28, 1959</u> , and that death occurred at <u>home</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. Hevan</u> M.D.		ADDRESS (Street, city or town, state) <u>Boonsboro, Md.</u>	
DATE SIGNED <u>4/24/59</u>			
PHYSICIAN'S NAME (Type) <u>G. W. Hevan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY-1-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bass</u>		ADDRESS <u>BOONSBORO MD</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

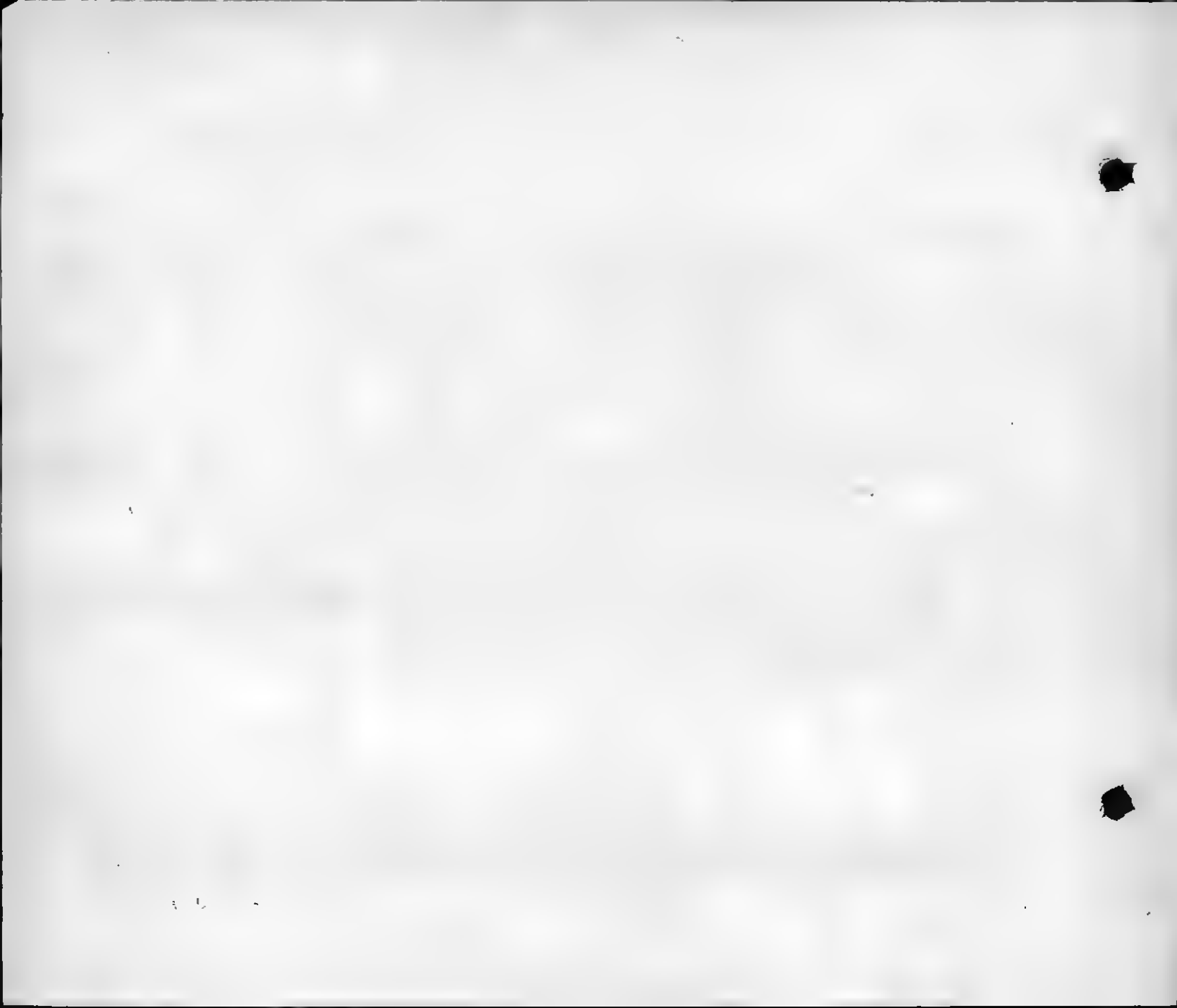
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4872

CERTIFICATE OF DEATH

Reg. Dist. No. 04882

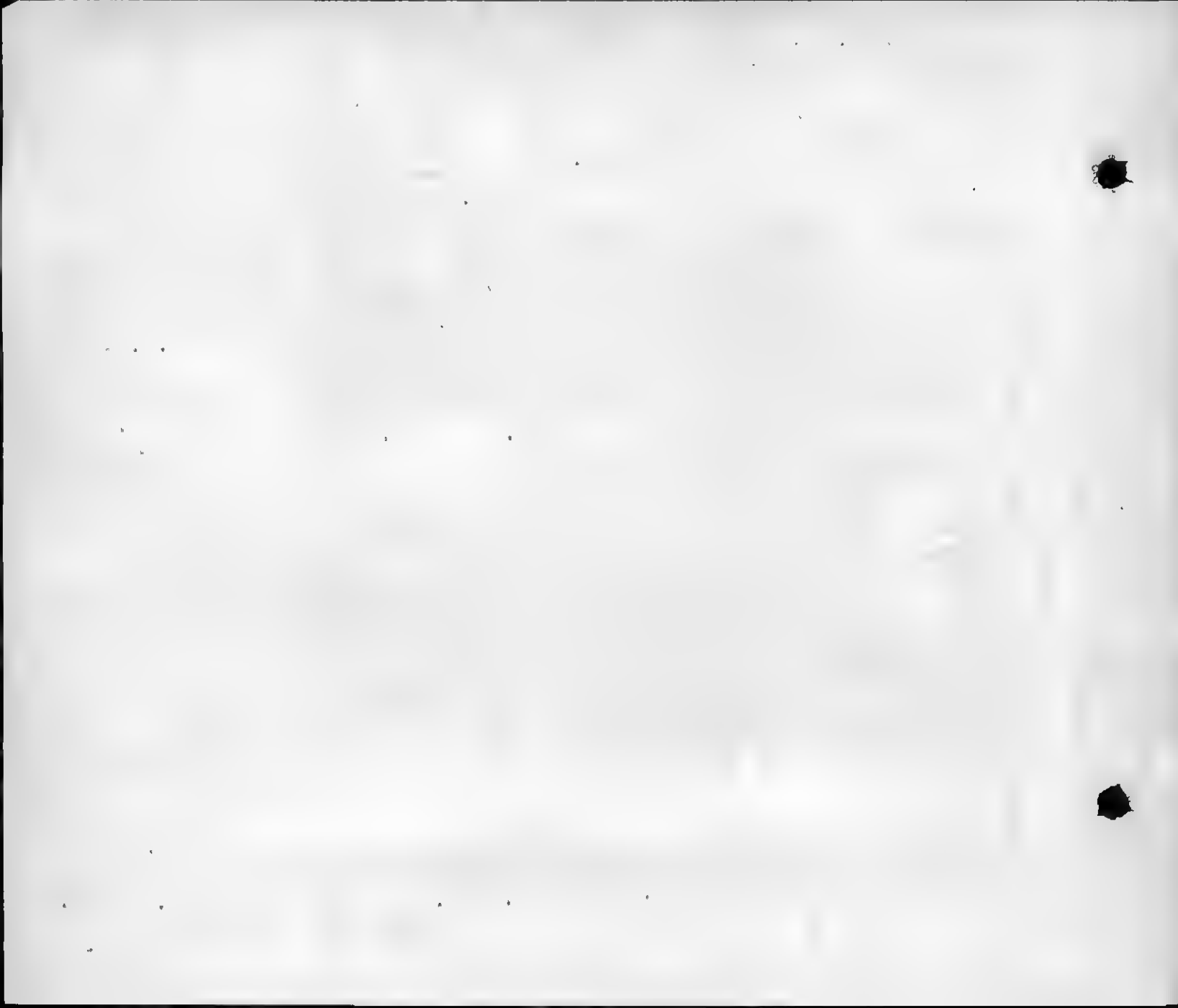
1. PLACE OF DEATH a. COUNTY FRANKLIN MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE PA b. COUNTY FRANKLIN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENCASTLE 75x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		d. STREET ADDRESS 257 So. WASHINGTON	
3. NAME OF DECEASED (Type or print) First IRA Middle O. Last STRITE		4. DATE OF DEATH Month APRIL Day 14 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 11, 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contractor	
11. BIRTHPLACE (State or foreign country) Leitersburg md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Strite		14. MOTHER'S MAIDEN NAME Catherine Maun	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Thos Mary Grace Strite		Address 257 S. Washington Greencastle Pa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ RHEUMATIC HEART DISEASE 75 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 9/1/39 to 4/14/59 , that I last saw the deceased alive on 4/14/59 , and that death occurred at 12:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE W. Q. Braver, M.D. M.D. Greencastle, Pa. PHYSICIAN'S NAME (Type) W. Q. Braver, M.D. Greencastle, Pa.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF April 17/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City or town, or county) (State) near Greencastle Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Cond E. N. Minich		24a. REC'D BY REGISTRAR Greencastle Pa	
24b. REGISTRAR'S SIGNATURE Arthur J. King		DATE APR 16 '59	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Countersigned										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04883																																																											
DME Wash. Co. Md. 4-10-59										S. Robert Wells, M.D.										CERTIFICATE OF DEATH		Reg. Dist. No.																																																									
1. PLACE OF DEATH a. COUNTY					WASHINGTON					MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE					MARYLAND					b. COUNTY					WASHINGTON																																																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					HAGERSTOWN					c. LENGTH OF STAY IN 1b					80 YRS.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					RURAL CLEARSRING																																																						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION										MARTIN MANOR REST HOME										d. STREET ADDRESS										RT.#1 CLEARSRING										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
3. NAME OF DECEASED (Type or print)					First HESTER					Middle ANN					Last SWOPE					4. DATE OF DEATH					Month APRIL					Day 7					Year 19 59																																												
5. SEX					FEMALE					6. COLOR OR RACE					WHITE					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH					8/23/1865					9. AGE (In years last birthday) 93 yrs.					IF UNDER 1 YEAR Months Days Hours Min					IF UNDER 24 HRS																																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										HOUSEWIFE										10b. KIND OF BUSINESS OR INDUSTRY										HOME										11. BIRTHPLACE (State or foreign country)										MARYLAND										12. CITIZEN OF WHAT COUNTRY?										U.S.A.									
13. FATHER'S NAME										JACOB KLINE										14. MOTHER'S MAIDEN NAME										MARTHA SWOPE																																																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)										NO										16. SOCIAL SECURITY NO (If yes, give war or dates of service)										NONE										17. INFORMANT Address										MRS. VIOLA G. BLOYER										CLEARSRING MD.																			
MEDICAL CERTIFICATION																				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia 3X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic Heart Disease DUE TO (c)																				INTERVAL BETWEEN ONSET AND DEATH 48 hours unknown																																							
																				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of the Right hip incurred in a fall 3/28/59																				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
																				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home																																																	
20c. TIME OF INJURY Hour 0000 p.m. Mar 28 1959										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home										20f. (City or town) Rural Clearspring Wash Md										(County) (State)																																							
21. I certify that I attended the deceased from March 28, 1959, to April 7, 1959, that I last saw the deceased alive on April 7, 1959, and that death occurred at 7:15 P.M. from the causes and on the date stated above.																				ADDRESS (Street, city or town, state)										DATE SIGNED																																																	
ACTUAL SIGNATURE Archie Robert Cohen										M.D.																																																																					
PHYSICIAN'S NAME (Type)										Archie Robert Cohen, M.D.										Clear Spring, Maryland										April 9, 1959																																																	
22a. BURIAL, CREMATION, REMOVAL (Specify)										BURIAL										22b. DATE THEREOF										4/9/59										22c. NAME OF CEMETERY OR CREMATORY										ST. PAULS CH. CEM.										22d. LOCATION (City, town, or county)										WASHINGTON CO. MD.									
23. FUNERAL DIRECTOR'S SIGNATURE										W. J. Harwood										ADDRESS										Hagerstown										24a. REC'D BY REGISTRAR DATE										APR 13 '59										24b. REGISTRAR'S SIGNATURE										Arthur S. Frank									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4901

CERTIFICATE OF DEATH

Reg. Dist. No.

04884

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KEEDYSVILLE c. LENGTH OF STAY IN TB 50 YEARS		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KEEDYSVILLE d. STREET ADDRESS KEEDYSVILLE MD. FARM e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES KEEDY TAYLOR		4. DATE OF DEATH APRIL 24 - 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 7 - 1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER-FREDERICKA COLA PLANT.		10b. KIND OF BUSINESS OR INDUSTRY LA CROSSE KANSAS	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES BAKER TAYLOR		14. MOTHER'S MAIDEN NAME ETIA ELIZABETH KEEDY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-6160	
17. INFORMANT MRS. MARTHA TAYLOR KEEDYSVILLE MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic Carcinoma of the Gall Bladder DUE TO (b) 8 mos. (9) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Feb 24, 1959 , to April 24, 1959 , that I last saw the deceased alive on April 24, 1959 , and that death occurred at 10 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE Walter H. Shealy M.D. ADDRESS (Street, city or town, state) SHARP 56489, Md. DATE SIGNED 4/25/59 PHYSICIAN'S NAME (Type) Walter H. Shealy M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APR 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		22d. LOCATION (City, town, or county) (State) KEEDYSVILLE WASH. CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE John H. East		24a. REC'D BY REGISTRAR DATE APR 30 '59	
ADDRESS BOONSBORO MD		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4902 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04885

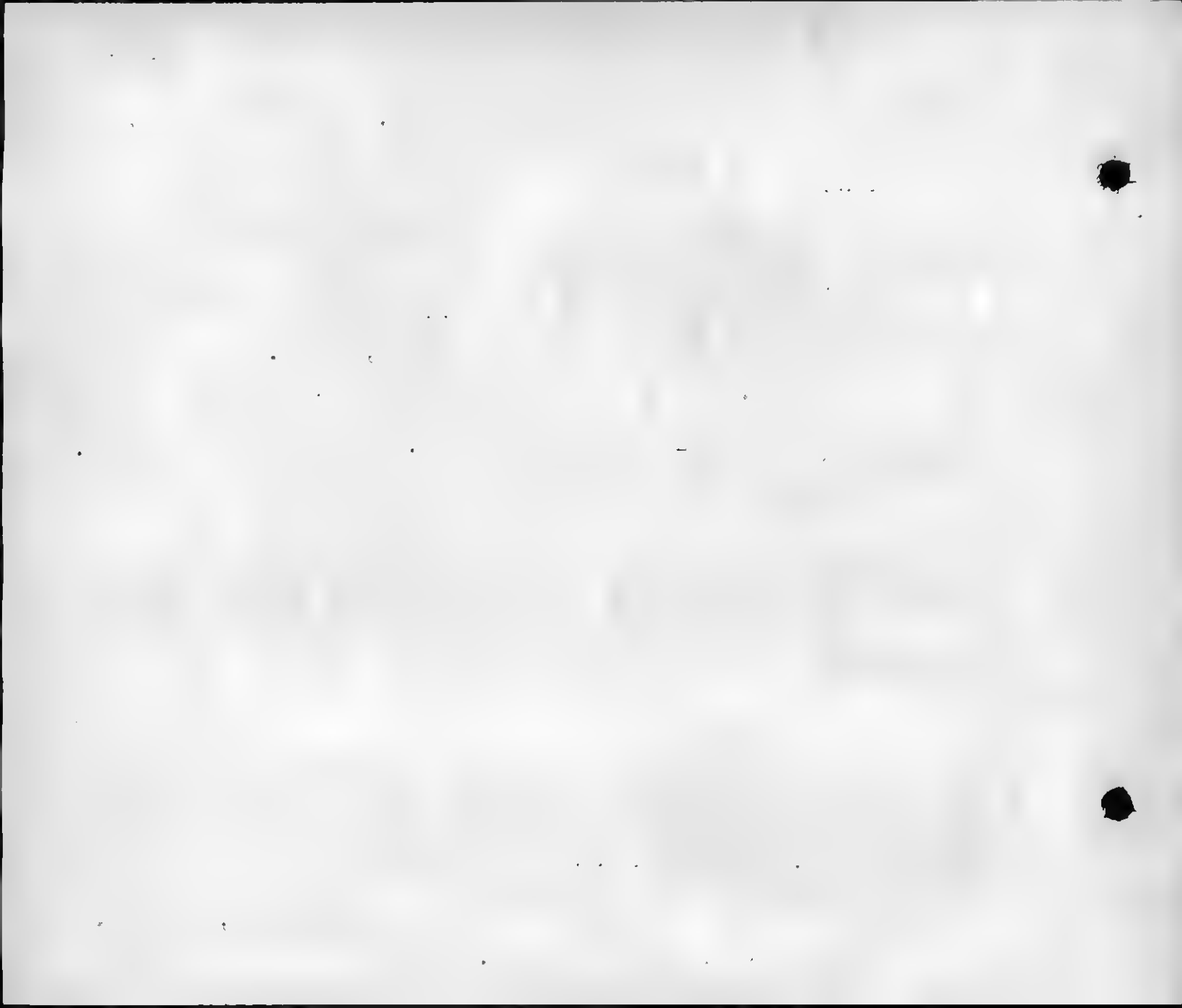
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Smithsburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Smithsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD 2</u>		d. STREET ADDRESS <u>RFD 2</u>	
3. NAME OF DECEASED (Type or print) <u>Harrison Francis Walter</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Fairfield, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Conrad C. Walter</u>		14. MOTHER'S MAIDEN NAME <u>Lucy M. Cool</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>220-28-3072</u>	
17. INFORMANT <u>Lawrence E. Walter, Waynesboro, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u>None</u> 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
20f. (City or town) <u> </u>		(County) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		DATE SIGNED <u>4-17-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Apr. 18, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home, Smithsburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Christina L. Thomas</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, willing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

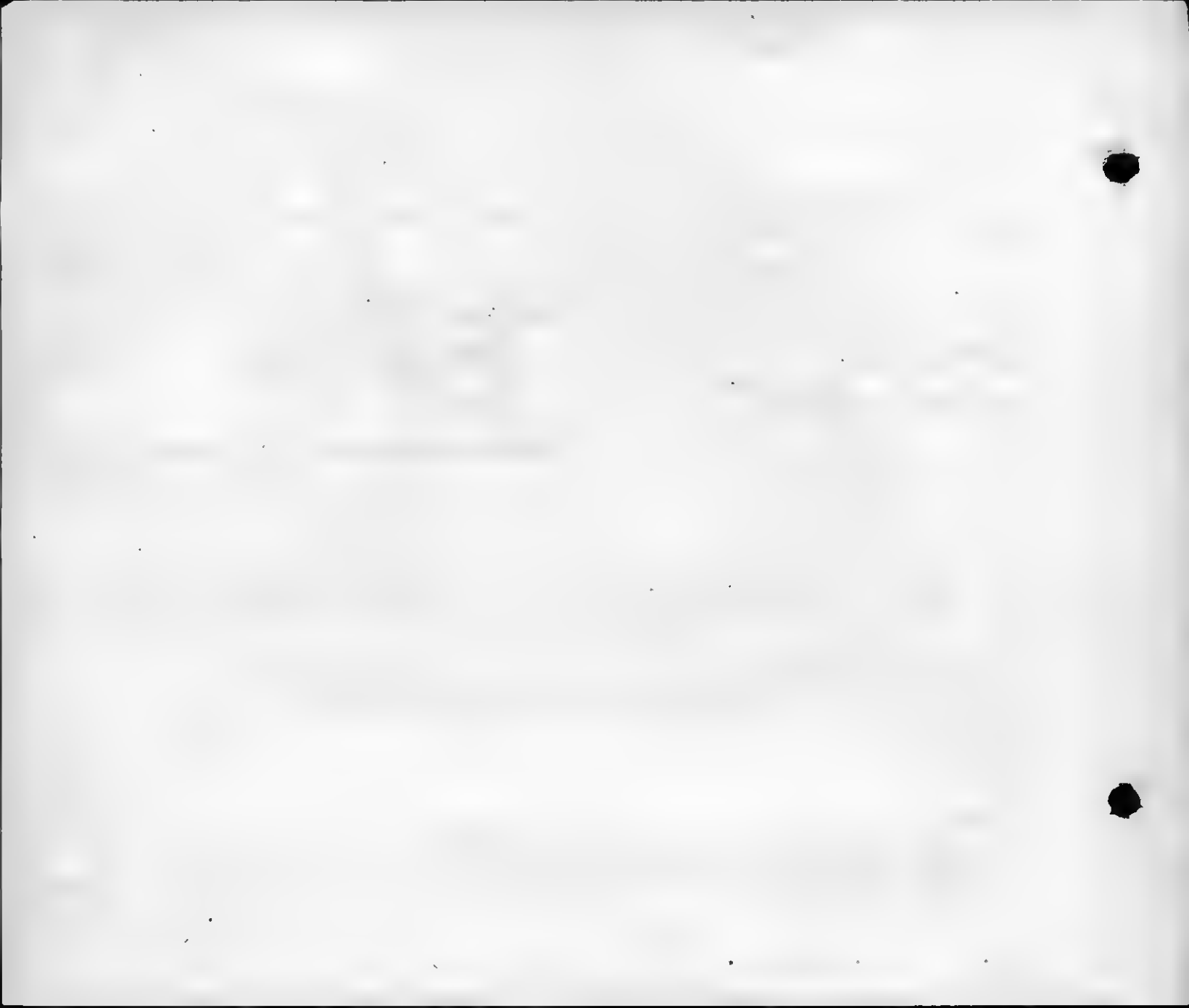
4874

CERTIFICATE OF DEATH

04886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> <u>MD.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
c. LENGTH OF STAY IN 1b <u>9-30-58/4/8-59</u>			d. STREET ADDRESS <u>1606 E - Fleet ST.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Md. State Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>L.</u> Last <u>Walters</u>			4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1959</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1901</u>		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Raleigh, W. Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Hunt</u>			14. MOTHER'S MAIDEN NAME <u>Annie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT <u>Mrs. Doris Sullivan 2409 E. Fairmount</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY CONGESTION & EDEMA</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALISED CARCINOMATOSIS</u> (c) <u>SQUAMOUS CELL CARCINOMA OF CERVIX</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>3 MONTHS</u> <u>16 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 30</u> , 19 <u>58</u> , to <u>April 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>59</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Victor L. Ramos</u>			M.D. <u>Western Md. State Hospital</u> <u>April 19/59</u>		
PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS</u>			<u>Hagerstown, Maryland</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u> ADDRESS			24a. REC'D BY REGISTRAR <u>APR 13 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4903

CERTIFICATE OF DEATH

04887

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock Md		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Edith Middle Amelia Last Weller		4 DATE OF DEATH Month 4 Day 30 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1. 1886
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 6 Days 29	11. IF UNDER 24 HRS Hours 29 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11 BIRTHPLACE (State or foreign country) Washington Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Known		14 MOTHER'S MAIDEN NAME Ida Shives	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Nina Wilson Hancock Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15-20 min 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 7 , 19 58 , to April 30 , 19 59 , that I last saw the deceased alive on April 29 , 19 59 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank B Thomas III M.D.		ADDRESS (Street, city or town, state) 121 High Street	
PHYSICIAN'S NAME (Type) Frank B. Thomas III, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5.3.59	
22c. NAME OF CEMETERY OR CREMATORY Stone Bridge Brothorn		22d. LOCATION (City, town, or county) (State) Near Hancock Washington Md.	
23 FUNERAL DIRECTOR'S SIGNATURE Hancock & Shore Hancock Md		24a. REC'D BY REGISTRAR May 5 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

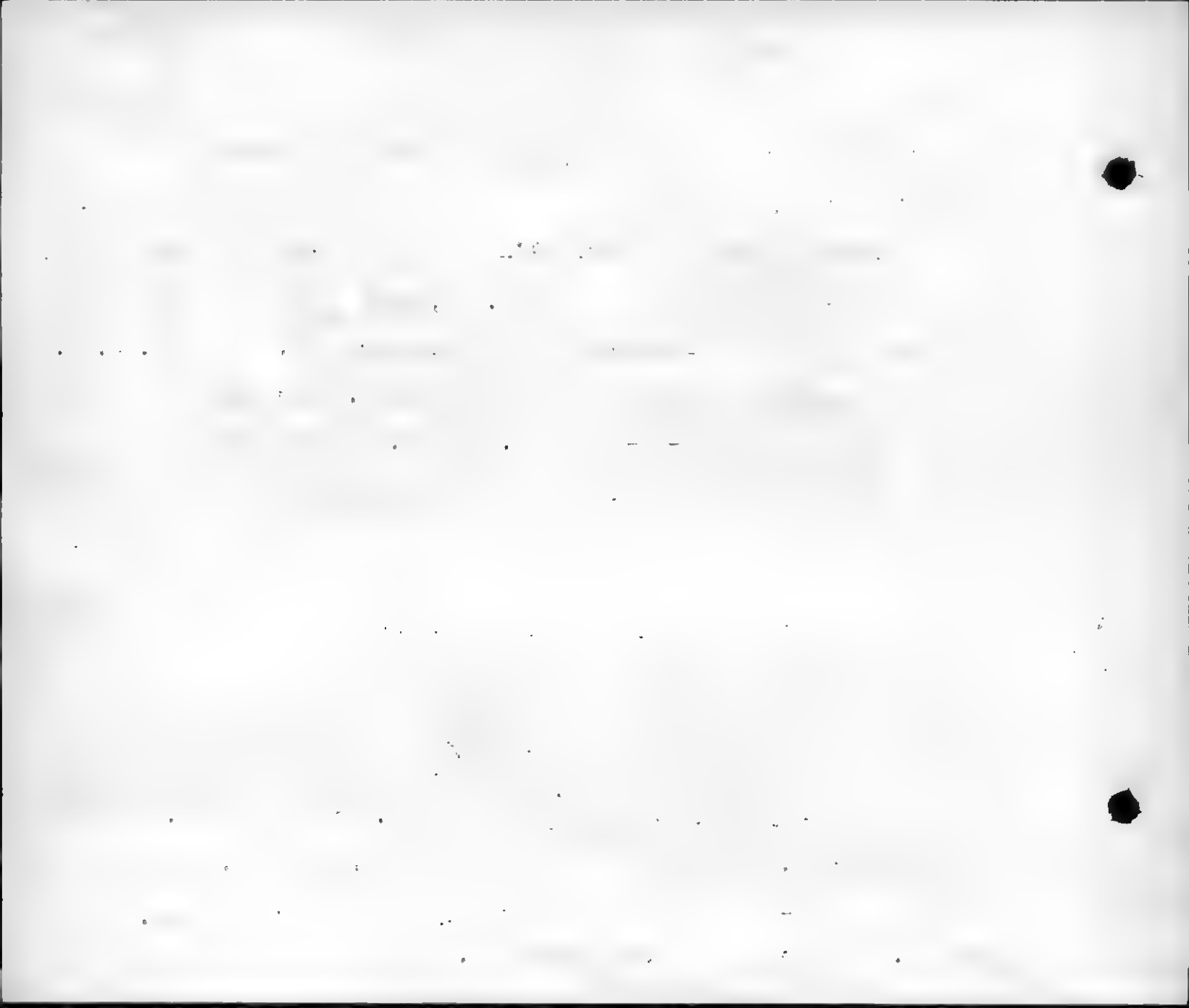
4875

CERTIFICATE OF DEATH

04888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown d. STREET ADDRESS Route 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lewis Henry Wiebel III		4. DATE OF DEATH April 10 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1906
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Augustus Wiebel		14. MOTHER'S MAIDEN NAME Mattie O. Wushbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-0721	
17. INFORMANT Mrs. Mary B. Wiebel		Address Route 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (c) Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) nephrosclerosis, uremia			INTERVAL BETWEEN ONSET AND DEATH 4 day indef
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar 7, 1959 to April 10, 1959 , that I last saw the deceased alive on April 9, 1959 , and that death occurred at 4:35 a. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert V. Campbell M.D.		ADDRESS (Street, city or town, state) 145 W. Washington St.	
PHYSICIAN'S NAME (Type) Robert V. Campbell		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-12-59	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR APR 14 '59		24b. REGISTRAR'S SIGNATURE Charles L. H...	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

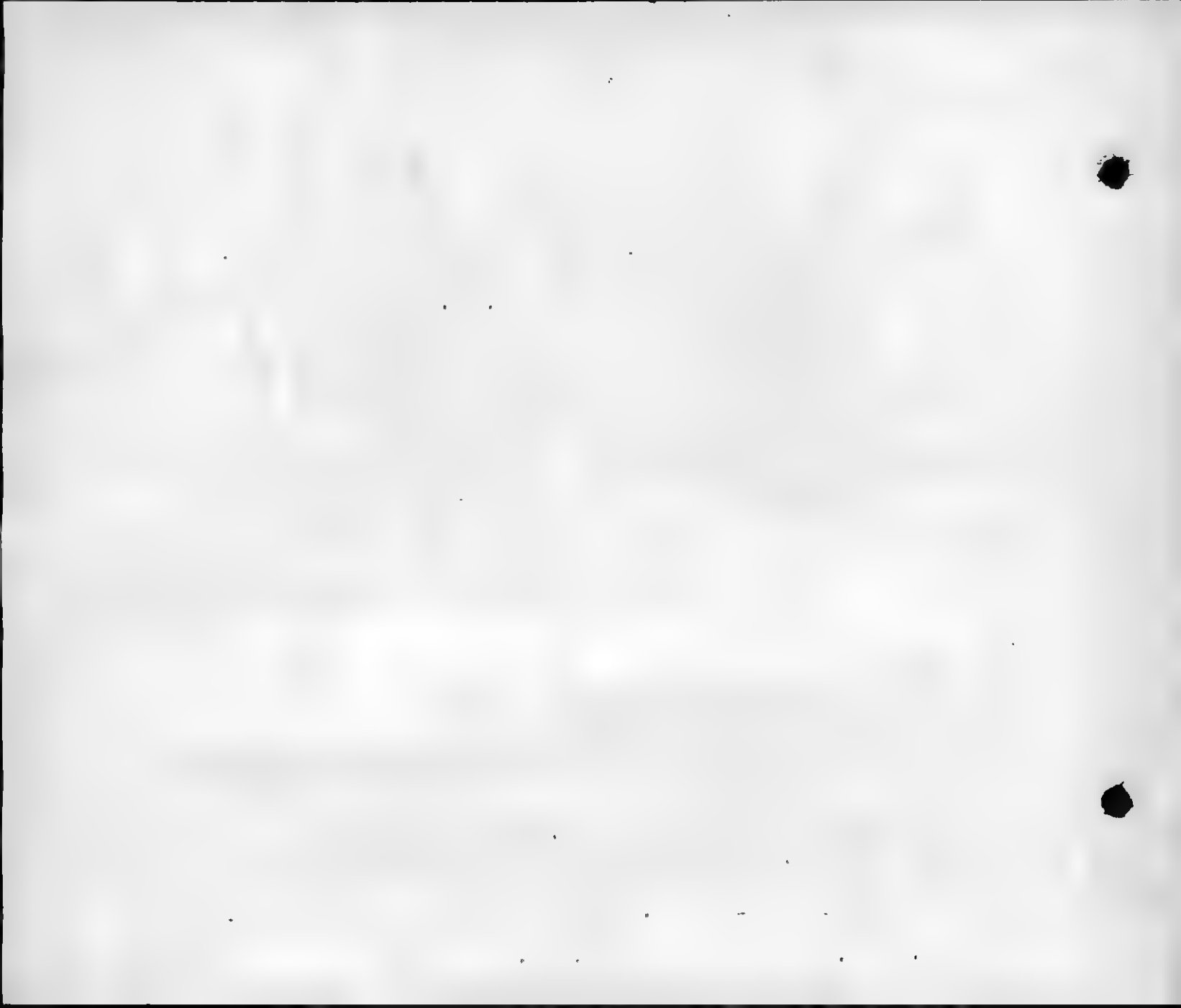
04889

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b 3 1/2 mos		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wash		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clara Easter Willard		4. DATE OF DEATH		Month Apr.		Day 14		Year 19 59		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 27, 1875		9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. CITIZEN OF WHAT COUNTRY? USA		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Wesley McAfee		14. MOTHER'S MAIDEN NAME Hannah Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No no		16. SOCIAL SECURITY NO 215-18-2203		17. INFORMANT Address Reeder Nursing Home - Boonsboro, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular renal disease 260X DUE TO (b) Diabetes M Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene foot		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Jack H. Beachley, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-15-59		EXAMINER'S NAME (Type) Jack H. Beachley, MD		Assistant Medical Examiner <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		22d. LOCATION (City, town, or county) (State) Foxville, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE Apr 20 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



4876

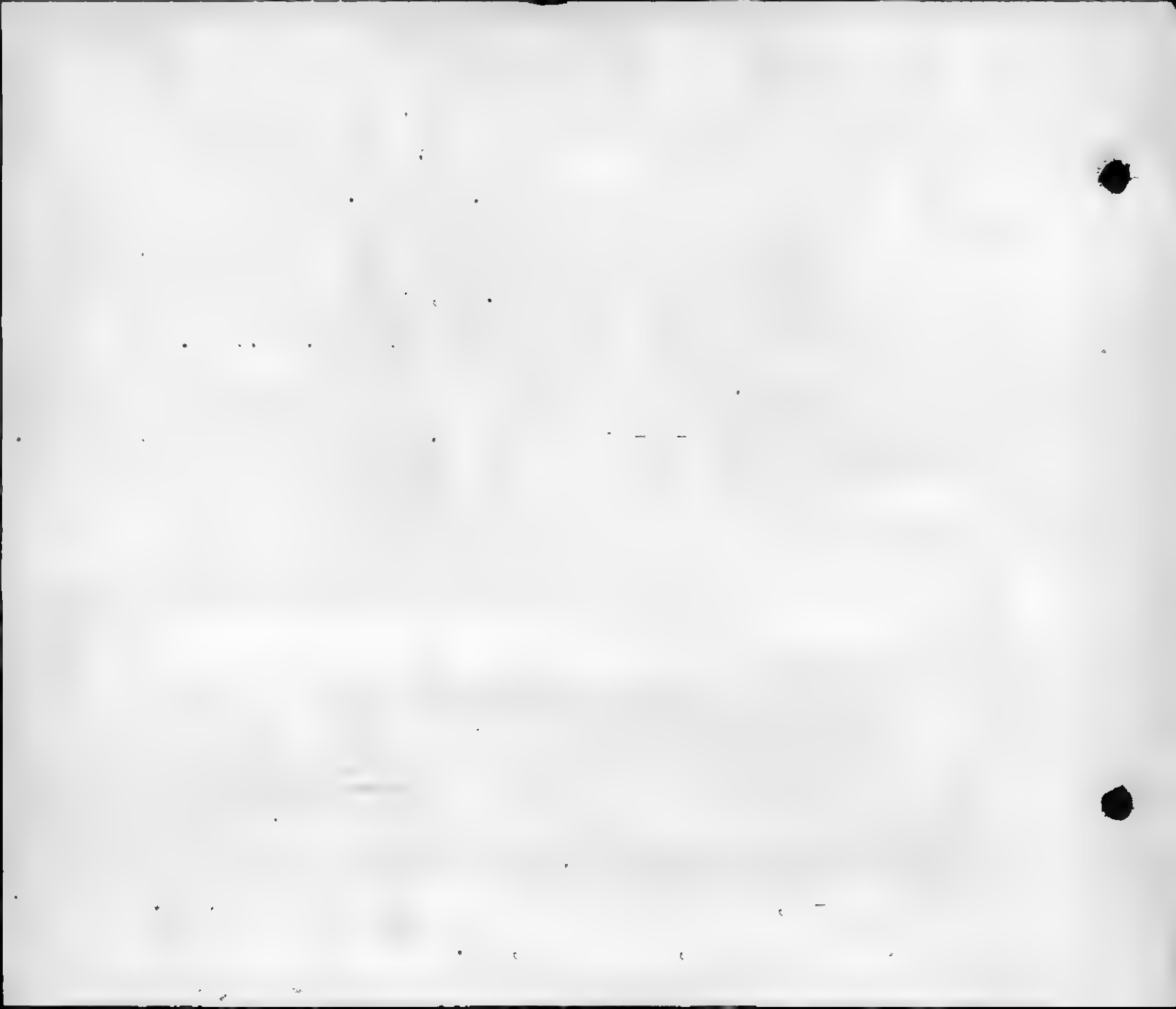
CERTIFICATE OF DEATH

04890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harvey Edward Williard		4. DATE OF DEATH Month Day Year April 22, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1918
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mason		10b. KIND OF BUSINESS OR INDUSTRY construction work	
11. BIRTHPLACE (State or foreign country) Lantz, Fred. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert D. Williard		14. MOTHER'S MAIDEN NAME Virgie A. Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-10-3954	
17. INFORMANT Address Joseph W. Williard Smithsburg, Rd1, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Alcoholic intoxication</u> DUE TO (c) <u>Alcoholic intoxication</u>			INTERVAL BETWEEN ONSET AND DEATH 1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-7-54, 19, to 4-25-59, 19, that I last saw the deceased alive on 4-25-59, 19, and that death occurred at 11:40 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles F. Hess M.D.		Smithsburg, Md.	
PHYSICIAN'S NAME (Type) Charles F. Hess			
22a. BURIAL CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 4-25, 1959	22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cem	22d. LOCATION (City, town, or county) (State) Smithsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE APR 27 '59	
		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4877

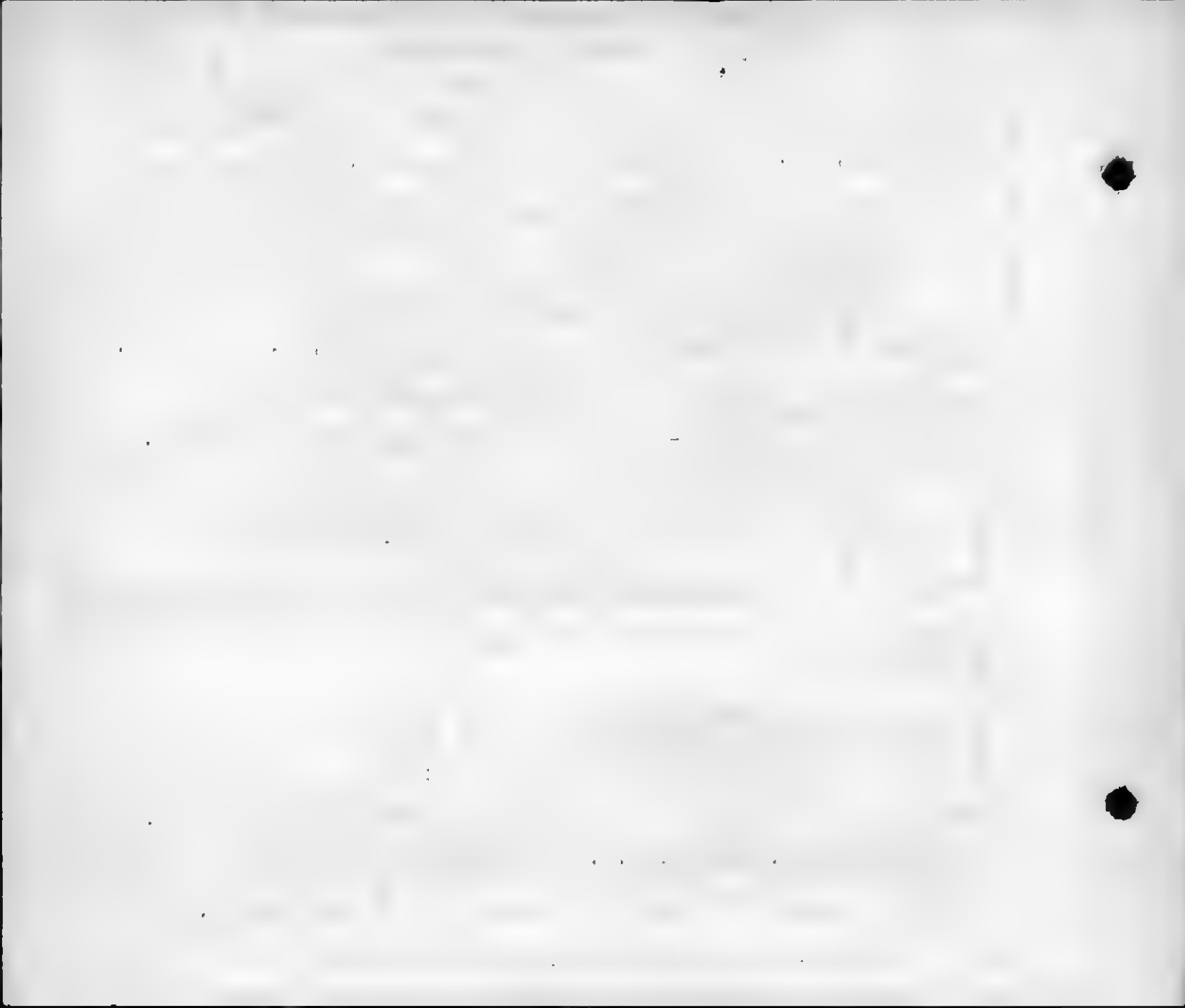
CERTIFICATE OF DEATH

04891

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.				c. LENGTH OF STAY IN 1b 20yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				/ d. STREET ADDRESS 400 B Park Place			
3. NAME OF DECEASED (Type or print) First Middle Last George Ezekiel Wilson				4. DATE OF DEATH Month Day Year 4 3 1959			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 5 1905		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rec. Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Charlestown W. Va.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Magie Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 236-14-1057		17. INFORMANT Address Mary E. Wilson 400B Park Place.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary emphysema and bronchial asthma DUE TO (c) 1 year						INTERVAL BETWEEN ONSET AND DEATH 22 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2 1959 to April 3 1959 , that I last saw the deceased alive on April 2 1959 , and that death occurred at 12:15 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 100 Professional Arts Bldg. 4/4/59							
ACTUAL SIGNATURE William T. Layman				M.D. 100 Professional Arts Bldg. 4/4/59			
PHYSICIAN'S NAME (Type) William T. Layman, M.D.				Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-1959		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John R. Watson Jr. Hagerstown Md.				24a. REC'D BY REGISTRAR DATE APR 7 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4878

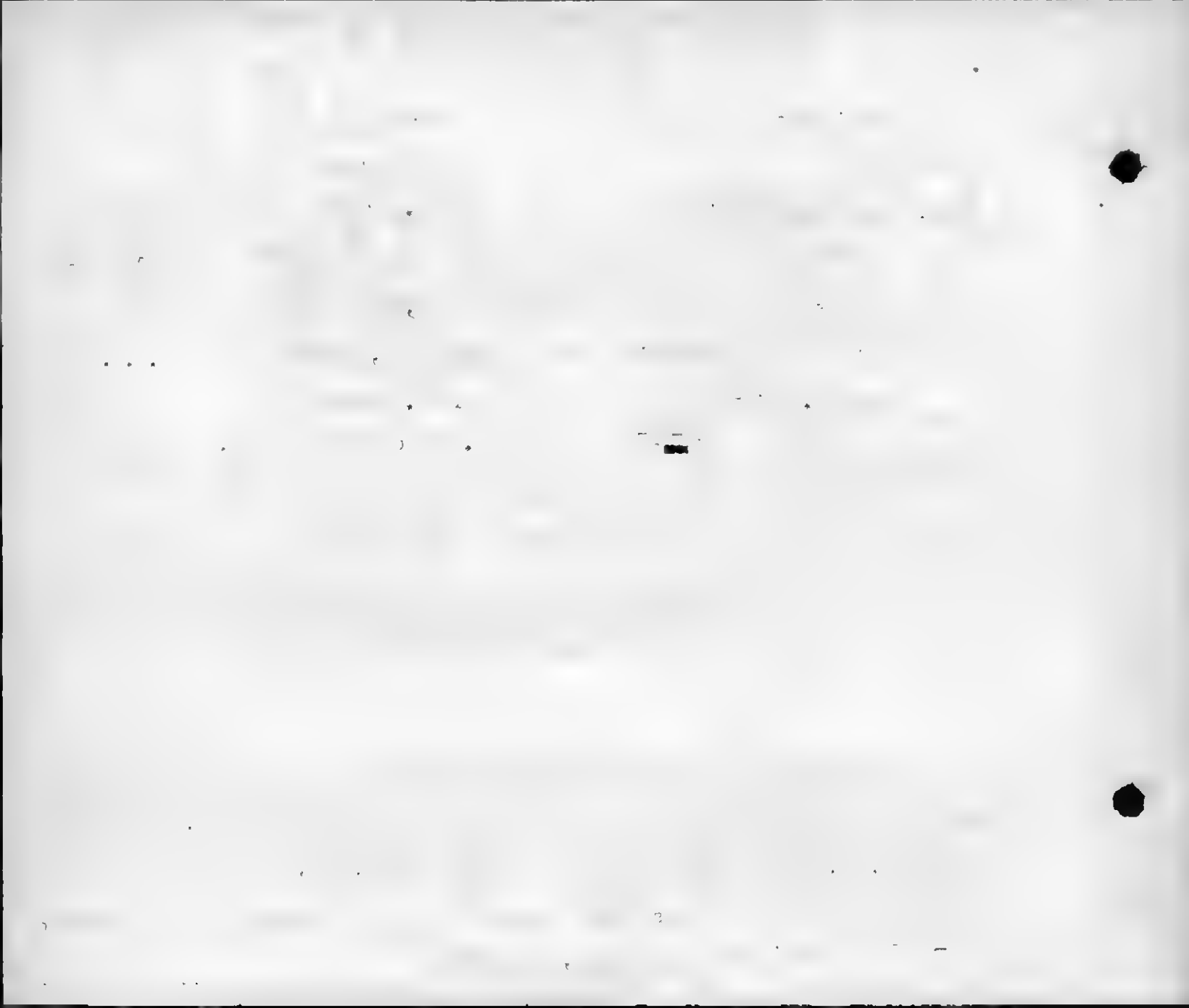
CERTIFICATE OF DEATH

04892

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 439 W. Franklin Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY CATHERINE WOLFE		4. DATE OF DEATH Month April Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1871
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR Months 4 Days 23 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Floor Lady		10b. KIND OF BUSINESS OR INDUSTRY Commercial Laundry	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel H. Switzer		14. MOTHER'S MAIDEN NAME Mary J. Lawrence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-18-1337	
17. INFORMANT Edgar W. Wolfe		Address Baltimore, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 23, 1959 to April 3, 1959 that I last saw the deceased alive on April 2, 1959 and that death occurred at 10:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. B. Kneisley		ADDRESS (Street, city or town, state) 148 West Washington St. Hagerstown, Md.	
DATE SIGNED 4/4/59			
PHYSICIAN'S NAME (Type) Dr. B. B. Kneisley		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1959	
22c. NAME OF CEMETERY OR CREMATORY Rome Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Kouzer Funeral Home		ADDRESS Hagerstown, Maryland	
24a. REGISTERED BY APR 8 1959		24b. REGISTRAR'S SIGNATURE William L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4879 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04893
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 6YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS 327 MITCHELL AVE.	
3. NAME OF DECEASED (Type or print) First GEORGE Middle WILLIAM Last YOUNGBLOOD		4. DATE OF DEATH Month APRIL Day 23 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1889
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LINEMAN		9b. KIND OF BUSINESS OR INDUSTRY ELEC. POWER CO.	
10a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. FATHER'S NAME ADAM YOUNGBLOOD		12. MOTHER'S MAIDEN NAME LOUISE WHORTON	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		14. SOCIAL SECURITY NO. 214-10-5334	
15. INFORMANT MRS. EMMA W. YOUNGBLOOD		Address HAGERSTOWN MD.	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma		INTERVAL BETWEEN ONSET AND DEATH 10 min	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour None 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/26/59	
22c. NAME OF CEMETERY OR CREMATORY GREENWAY CEM.		22d. LOCATION (City, town, or county) (State) BERKLEY SPRINGS W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horowitz, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE APR 28 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

DATE SIGNED

April 25 1959

4905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 20days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home				d. STREET ADDRESS 122 Williams Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Henry Zepp Jr.				4. DATE OF DEATH Month Day Year April 13 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1900		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Sand Blast		11. BIRTHPLACE (State or foreign country) Martinsburg W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Zepp Sr				14. MOTHER'S MAIDEN NAME Catherine Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address Mrs. Catherine Rickard Hag. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 Acute Cardio Vascular Dis DUE TO (b) Chr. Valvular Dis DUE TO (c) Chr. Valvular Dis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia Rt side						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 20, 1959 to April 13, 1959 that I last saw the deceased alive on April 13, 1959 and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Clear Spring Md.		DATE SIGNED 4/15/59			
PHYSICIAN'S NAME (Type) David R. Brewer		Clearspring Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-59		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR APR 20 59		24b. REGISTRAR'S SIGNATURE Clara E. Hager	

1905

Washington London Amsterdam

London Amsterdam 1905

Amsterdam

Colonel George Jones

185 William St.

John Henry Jones Jr.

April 13

Wife Wife

185 William St.

Amsterdam London 1905

U. S. 1905

Amsterdam

John H. Jones

Mrs. Catherine Jones

David H. Jones

Amsterdam

1905

Amsterdam

1905